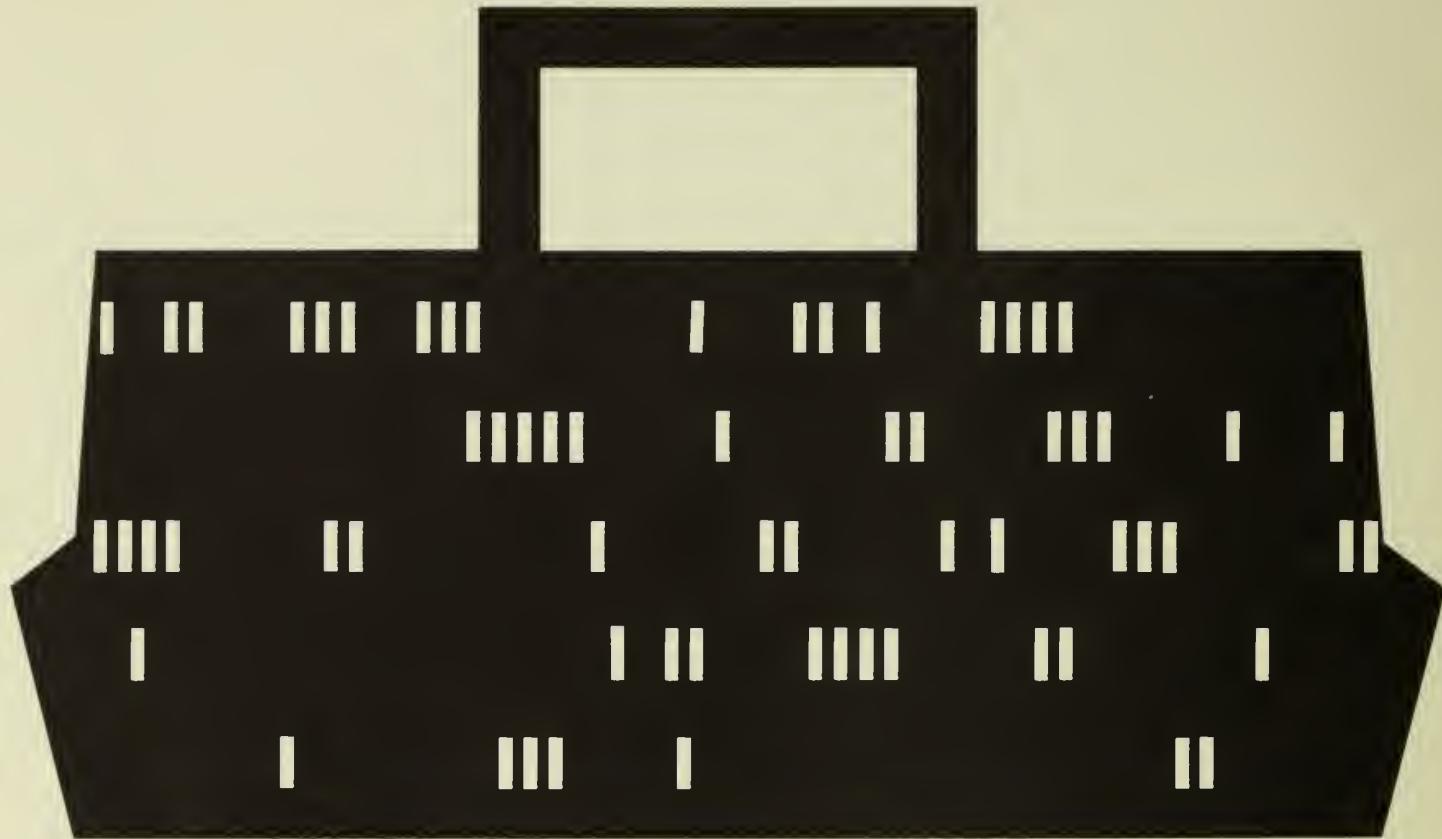


Anniversary Issue

HARVARD MEDICAL ALUMNI BULLETIN

“WHEN LIFE BEGINS”

Fall 1967



medicine in the 21st century

Harvard Medical
Conference

Ambassador Hotel
Los Angeles
California

Sunday, November 5, 1967
10 a.m. - 5 p.m.
5:45 p.m. cocktails
6:30 p.m. dinner

The program will include:

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Dean

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John P. Merrill, M.D.
Associate Professor of Medicine

Sidney Farber, M.D.
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John H. Knowles, M.D.
General Director, Massachusetts
General Hospital

Moderator: Langdon Parsons, M.D.
Clinical Professor of Gynecology,
Emeritus

HARVARD MEDICAL
ALUMNI BULLETIN
Vol. 42 Fall 1967 No. 1

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**40th ANNIVERSARY ISSUE
1927-1967**

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The opinions of contributors to the Bulletin do not necessarily reflect those of the Editorial Staff.

EDITORIAL

Of Bulletins, Past and Present

The *Harvard Medical Alumni Bulletin*, which eventually achieved a considerable degree of stability, is the direct if not the immediate result of the founding of the Harvard Medical Alumni Association over seventy-six years ago. According to minutes designated as those of the annual meeting of the Association on June 28, 1892, the first meeting of the Executive Committee had been held on August 14 of the previous year, when it had been voted to issue a bulletin containing an account of the first annual meeting to "be sent to every graduate of the School whose address could be obtained."

A subsequent meeting of the Committee took place on January 30, 1892, "to consider the advisability of printing a Catalogue. . . . The Treasurer and Secretary were appointed a Publication Committee, authorized to publish a Catalogue in an edition of 2,500 copies" to be sent to every graduate of the School—and the Association was in the publishing business. And yet again, at a special meeting of the Council held on February 10, 1893, it was voted to publish a Bulletin containing information about the School, and the president and secretary were empowered to appoint a committee "to publish said Bulletin in conjunction with the Faculty of the School." It was obvious that the indifference of the alumni to the welfare and prestige of their medical alma mater had become a matter of concern.

Something seems happily to have happened, for a note attributed to Bulletin Number 4 of 1893 expresses the hope that the enterprise might be of interest to the older graduates and the alumni living at a distance from Boston, for on its reception would depend its regular publication. For the purpose, probably, of adding a note of subdued confusion to the subject, the intervening years seem to have been passed over, for the matter of a quarterly publication was again discussed at the annual meeting of the Association on June 25, 1901, when a committee was named "to publish such a journal." "To aid in this work, the President was requested to appoint as many correspondents as he might see fit in each large city and each state in the country."

The first issue of the *Quarterly of the Harvard Medical Alumni Association* was accordingly published in July, 1901, the project continuing until October, 1904, when Number 14 was distributed to its eager recipients, and there the publication ceased. In April, 1905, however, like Prometheus on the rebound, a new series began, again called the *Bulletin of the Harvard Medical Alumni Association*. In the issue of July, 1905, New Series, an editor was first mentioned; the favored person was David Cheever, 1901, secretary of the Association. In August, 1912, Robert M. Green, 1906, then secretary, assumed the editorial prerogatives and publication continued until April, 1914.

For thirteen years animation was then suspended; in the latter years of this period Elliott P. Joslin became president of the Association, the campaign for a dormitory was initiated and successfully completed and construction was well under way. Raising the funds for this project through one channel or another was undoubtedly the greatest single contribution of the alumni to their School and to the welfare of its students. It can be matched only by the long-term quietly persistent and increasingly successful efforts in behalf of the Medical Alumni Fund.

At the annual meeting of the Association in 1926 Philemon E. Truesdale of Fall River was elected president; at the first meeting of the Council that fall he proposed the publication of a bulletin so enthusiastically and convincingly that the resulting periodical has not failed nor faltered in the ensuing forty years. The new secretary of the Association, Joseph Garland, was appointed editor, and Albert A. Hornor, the organization's treasurer, was named as business manager.

The first number, issued in March, 1927, bore on its cover an appreciative message from President Lowell; each copy contained a postcard asking the recipient's opinion of the new venture.

Four thousand cards were thus distributed and 700 were returned, the senders of all but one approving of the publication; the sturdy leader of the minority by his own testimony had no time for reading. A minuscule number reported on their postcards that the *Bulletin* had not been received. Since the only method of distributing the cards was as enclosures in bulletins, an unsolved mystery as obscure as that of the *Marie Celeste* remains.

This brief account of the somewhat erratic history of the founding—and sometimes foundering—of your *Bulletin* raises some question in the minds of the present editors of the current publication with respect to what constitutes a bulletin, anyway. Having inherited, no doubt from their predecessors, a penchant for precise definition, they have ascertained that a bulletin, according to the irrepressible Mr. Webster, is "a brief statement from an official source concerning the current status of a source of prolonged interest (as of a war or the health of a sovereign) b: an announcement of future plans; esp. a college or university catalog c: a brief monograph; esp: one issued by a public agency to provide popular information" etc. etc.

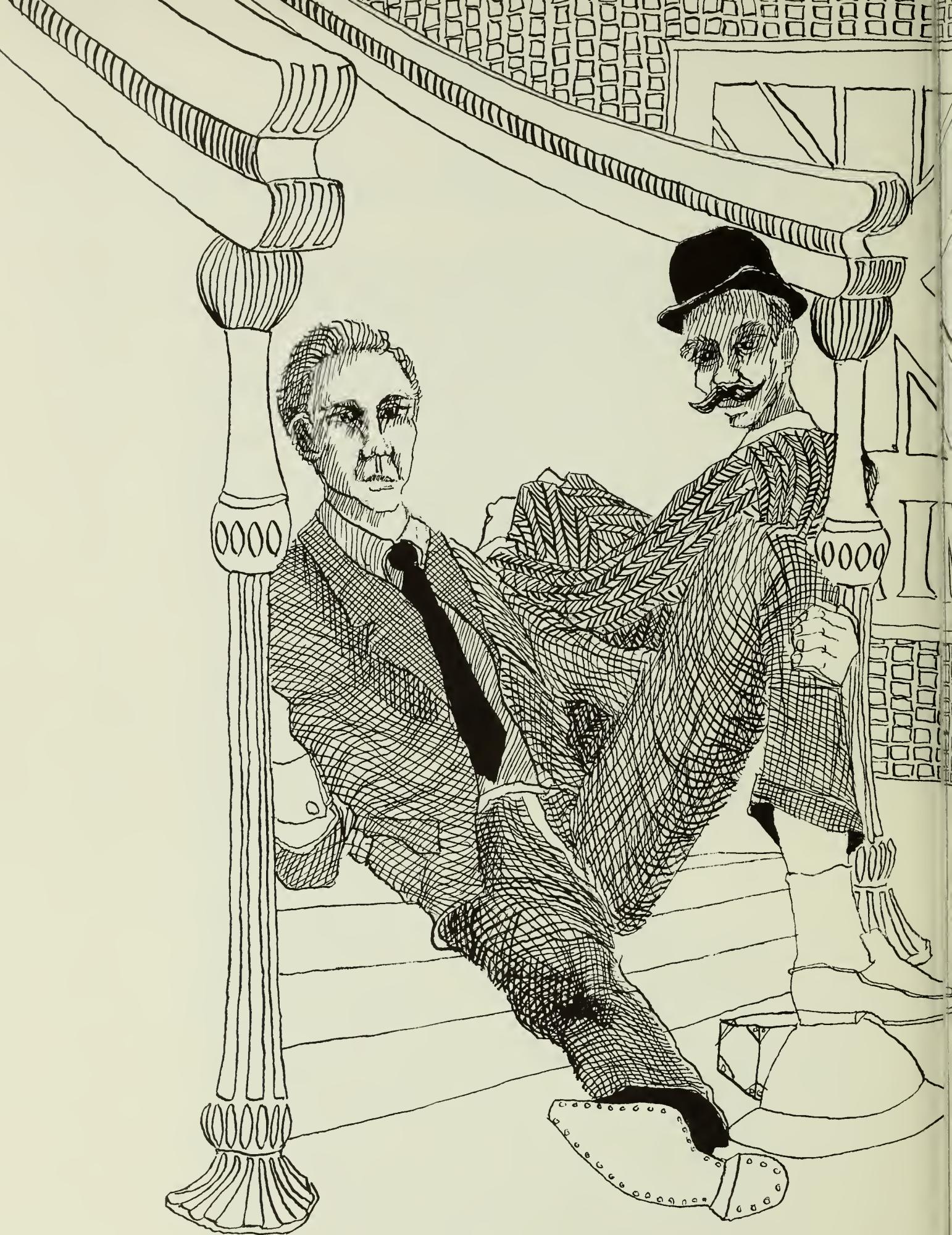
To call the "bulletin" a "journal" seems not to clarify the issue, for a journal may be a daily record, a book of original entry in double entry bookkeeping, a record of experiences etc. kept for private use, or a daily newspaper; it is often used in respect to official or semi-official publications, such as the *Journal of the American Medical Association*.

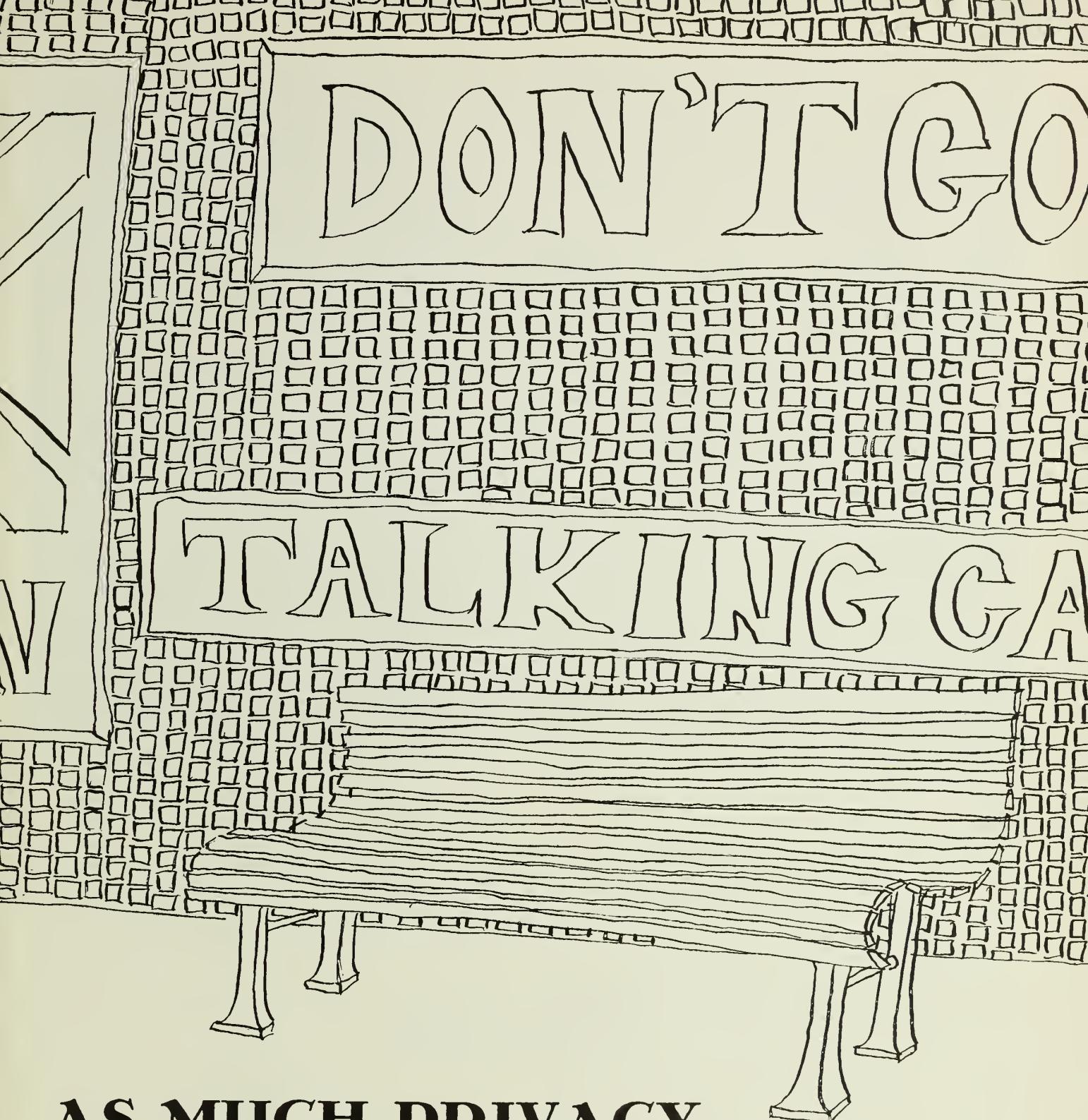
It therefore appears that a bulletin in the periodical sense may have some of the excellent characteristics of newspapers, journals or magazines, the last term applying also to "the room in which powder is kept in a fort or ship." Although some of these features seem not necessarily to resemble what was intended in 1927, the *Bulletin* has in general remained a bulletin during its forty years of existence under a succession of editors, with the indispensable help in recent years of a succession of extraordinarily well qualified lady associate and assistant editors.

Now, by a curious set of chances, as Gilbert would have expressed it, the wheel has come full turn and appears again equipped with its original tire, retreaded. Any new editor, incidentally, regardless of previous experience with the *Bulletin* or any other publication may feel a little diffident in the face of the dozen successful years that John Brooks has just completed. But the harbor is cleared, the furrow follows free, and when a pilot is dropped, as John himself put it in the last issue, someone must take the ship along one course or another.

The *Bulletin*, owned and published by the Alumni Association, is financially underwritten by the School, obviously on a *quid pro quo* basis. Representative, in the true Harvard tradition, of a free press, it has as its important function that of serving as a friendly medium of communication between the alumni and their School, whose welfare is of such concern to them. This concern is expressed through the *Bulletin* in original papers and in letters to the editor, by direct communication with the administrative officers and by the continuing and generally increasing generosity of their contributions to the School's support.

The *Bulletin* should serve with at least equal effect as the medium through which the School's policies and its activities in education, public service and major research are interpreted to the alumni. This mutual respect and confidence represents a relation that should be invaluable to each and must be assiduously maintained.





DON'T GO

TALKING GA

AS MUCH PRIVACY...

by N. Paul Hudson '25

LATE one afternoon, just as I was stepping into the tub, the chilling wail of air-raid sirens filled the air and I heard enemy planes pulsing high overhead. I was on the top floor of the Institute where the one bath in the building was located. Instinctively spurred to escape threatening danger, I finished my bath with uncommon haste and retreated dripping to my laboratory-office-sitting room-dressing room on a lower floor. While I was dressing for dinner, there was a knock on the door, and a young woman scientist burst into the room. She sat down in the sitting room, and while I completed dressing, we discussed the next day's work.

Equipped with the customary helmet and gas mask, I traveled by tube from Hampstead to the Athenaeum Club where I met a friend. As we chatted leisurely over a scotch and soda, the traditional calm of the club was broken by the noise and vibration of a bomb falling not far away. But by seven o'clock, there was a lull in aerial activity, so we took a taxi to an apartment in Mayfair, where our host and hostess entertained us genially with liquid cheer and pleasant conversation. Soon another couple joined us, and we all decided to make our way cautiously to the Players' Theatre—an enterprise supporting idle actors and entertaining theater-starved blitzers. We joined

the merry throng at tables scattered around a bare, smokey, low-ceilinged room in a sub-basement, where a small improvised stage had been set up.

The show began under the direction of a jovial master of ceremonies in stand-up collar, white stock, lace cuffs and dark frock coat. He introduced the actors who in song and monologue burlesqued the melodrama and sentimentality of the Gay 90's. With boisterous abandon the bohemian audience joined in the singing of familiar choruses, while the mobile-faced tragedian was heckled in his sad story of the lonely bachelor and the innocent doll. During the intermission, sausages, made largely from bread, were washed down with warm beer.

By this time, I was persuaded to seek relief from the accumulation of various fluids consumed. After some gentle elbowing, required under the crowded circumstances, I gained access to a dingy side-room, where simple unshielded facilities were temporarily provided, and severely taxed by the jostling throng of men.

With the conclusion of the last skit, the patrons forgot make-believe and came back to the realities of a night air-raid. As we stumbled up the unlighted steps, we were intermittently unmasked by irregular flashes in the street; bursts of light both small and sky-filling outlined the jagged rooftops of the surrounding buildings as bombs and incendiaries near and far played their flaming role. The night was filled with the crackle of anti-aircraft fire, overlaid by the swinging drone of enemy planes unseen.

Our mortal nakedness seemed exposed, and anxiously we searched for a taxi on the prowl. It took us to comforting cover and the roars and flashes of destruction were shut out, the common risks forgotten, or at least overlooked, in the comradeship of conversation, sustaining food and relaxing drink.

Time passed so quickly that it was after midnight before the hour was noticed. Guided by a hooded flashlight, my friend and I left for the Underground station at Piccadilly Circus. A stray taxi crept out of the dark and took my companion to his club and me to the station.

I boarded a train for King's Cross, expecting there to make the usual transfer to Hampstead. But the last train for the night had gone; I "should 'ave changed at Lei'ster Square." I was stranded. I climbed back up the stairs to the street to see if taxis or buses were about, but saw only towering shadows, stars against a black sky, an occasional distant bursting shell, and a few specks of light from private cars. I turned to find the gates being shut and locked for the rest of the night. Realizing that the Underground was my most certain refuge, I ducked back inside the barrier and apprehensively made my way to a lower station level.

As a foreigner, my feeling of being conspicuous was confirmed by my being challenged by an austere warden. But when the shelter's guardian found that the wanderer was indeed an outsider, he led me down the stopped escalator and pointed to a space on the tilefloor of the wide passageway between the platforms. It was an unoccupied spot among the sleepers, just large enough to accommodate me. But I, having nothing softer than a newspaper, asked and was granted permission to sit on an escalator step. The scant space was at the feet of another casual, an old gentleman of obvious daytime distinction with white collar, waxed moustache and bowler,

all in some disarray as he dozed.

It was 1:30 in the morning and all trains had stopped; there would be no more until five A.M. This was the short interval of safe repose. The sleepers, mostly adults, lay in tight rows covering the train platforms and passageways; only narrow aisles were left unoccupied. The residents appeared to be shopkeepers or clerks, who nightly chose to seek safety here, or perhaps their homes had been destroyed and they had no other place to sleep. Most were fairly well dressed in day clothes, some leaving on even their shoes. They lay on pallets with bedclothes of varied kinds and colors. Several hundred people being so closely packed in that confined space provided sufficient heat for their own comfort.

I was not inclined to sleep on the uncushioned step, so instead I watched the multitude spread out before me. It was never quiet. Sleepers stirred; some spoke softly to others of their family group; coughing was incessant and snoring excessive. There was a movement here and there as a blitizen turned over or rearranged his pillow. A woman lying nearby sat up to comb her hair and put it up in ringlets as her companion slept. Occasionally a man lit a cigarette and smoked unnoticed. A mother wove her way up the crowded escalator steps pulling her child along with one hand and clutching a piece of newspaper with the other. A young man came down from above, stepping carefully among the sleepers, and seeing me awake asked for a match. A baby cried in the distance, and another nearer. The coughing and snoring continued.

At about 4:45 A.M., the assembly stirred. A few women left with their bundles of bedding; presumably they were charwomen going to work. Several uniformed employees of the Underground passed through to the platforms, ready for the first trains. There was a stir above as the station gates were opened for the coming day. And promptly at five o'clock an almost empty train rolled in on its way to Hampstead.

Only two persons left the train with me at my station, and I felt conspicuous. Would yesterday's ticket be acceptable? What would happen at the station exit? Would a policeman suspect that an alien, detected by the cut of his clothes, had been out after midnight? Even "friendly aliens" were under restrictions, and if I were questioned my accent would be noticed.

The ticket was accepted. The policeman gave no heed to the early passenger.

Now the Institute. Could I get to my bunk in the underground shelter unnoticed? The watchman opened the locked door in answer to my ring: "Good morning."

It was 5:25 and no one was about. The shelter, dimly lit, was quiet. I climbed into bed. The night's experience faded into sleep.

By eight o'clock I was up for breakfast as usual. "Ah, here you are!" my table companion exclaimed. "Where were you last night during the raid?"

"At the Players' Theatre," I replied.

But he questioned me further: "Where is that? How long were you there? Then where did you go?"

Later, a fellow scientist, fire-watcher and shelter mate said: "I went off duty at twelve o'clock; you weren't in then. Where were you last night?"

And another, "I went to bed at three this morning. I didn't see you. Where were you last night?"

Chorus: "Where were you last night?"



Two Views of

HAITI'S

Hôpital Albert Schweitzer

I

From the Inside

by Frank J. Lepreau, Jr. '38

II

From the Outside

by W. Bart Saxbe, Jr. '67

From the Inside

The Artibonite Valley is lush and green six months of the year because of the rain that falls every afternoon in Haiti; but during the dry season, the parched land, and the canals choked with grass and dirt are signs of an unmistakable need. Life gives little evidence of the 20th century; machetes and long-handled heavy hoes are the only tools available for coaxing vegetation from the rocky land; cornmeal is pounded out in a hollow tree trunk; rice is winnowed by young children running barefoot through it. In the three years I have been here, I have not seen an animal- or tractor-drawn piece of farm machinery.

Precisely because it is underdeveloped, the Artibonite Valley was chosen as the site of Hôpital Albert Schweitzer. Ninety miles from Port-au-Prince, the last twenty over a seemingly bottomless mud road that presents major difficulties in transporting personnel and equipment, the 133-bed hospital was founded as a result of a particular coincidence of needs.

HAS came into being because William Larimer Mellon, Jr. and his wife wanted to help somebody, somewhere. After his freshman year at Princeton, Mellon left college and pursued various careers until World War II, when he was an undercover agent in Portugal, Spain, and Switzerland. After the war he read Schweitzer's books and became so impressed with the man and his hospital work in French Equatorial Africa that he decided to follow his example. Dr. Schweitzer gave consent for his name to be used. At the age of 38, Larry Mellon re-entered college at Tulane University. It was while he was completing Medical School that he chose the Artibonite Valley because it seemed that there the need was greatest.

When told of the plans for the hospital, the Haitian government leased to Dr. Mellon 100 acres of land in the valley on a site previously used by an American fruit company. Some of the company's buildings were turned over to the Mellons and in 1954, construction of the hospital began. After serving two years at Charity Hospital in New Orleans, Dr. and Mrs. Mellon went to Haiti where they have been ever since. They opened their hospital on Dr. Mellon's birthday, June 26, 1956.

The hospital is a remarkably functional, one-story building surrounding a courtyard of grass, breadfruit, and almond trees. It operates busy out-patient departments where medical, surgical, and pediatric cases are examined and treated. A detailed chart on each patient is kept in the modern record room. There are eye and dental clinics, a well-stocked pharmacy, laboratory, and diagnostic X-ray department.

The primary health problems are malnutrition, tuberculosis, gastroenteritis, and tetanus of the newborn. In 1966, we saw 1,487 new cases of tuberculosis, 844 of which were pulmonary. They do surprisingly well with INH and PAS on an ambulatory basis. Patients requiring pulmonary surgery are kept in a tuberculosis rest house for two months before and after surgery. In 1966, 533 cases of tetanus were treated

of which 447 were tetanus neonatorum—a tragic and common-place infection found in most underdeveloped countries. In this country it is caused by putting charcoal or other contaminated materials on the cord stump. We attempt tetanus toxoid immunization of all persons coming into the clinic, but with 60,000 clinic visits a year the system sometimes breaks down. Twice a week during the school year, we send a team of a doctor, two nurses, and a recorder to all the schools in the area for PPD administration, and immunization with BCG, DPT and typhoid. During the last school year, 4,675 children were seen. In close association with the hospital, there is a community development program concerned with education and employment. Instruction and jobs are provided in woodworking, rug-making, ceramics, sewing, pig and poultry raising. Close by are an elementary school, a veterinary clinic, dairy herd and barn. Two years ago a large modern chicken coop was the scene of a grand fete for all the staff the night before the chickens moved in.

In this primitive area, peptic ulcer disease is common. The patients present with pyloric obstruction. Gall stones, appendicitis, and cancer of the colon are rare. Cancer of the stomach is common. We take many chest X-rays, but the only patient with lung cancer was a heavy cigarette smoker from Port-au-Prince. We rarely see arteriosclerosis in any form.

The average daily hospital census is 160. Over half are pediatric cases, and there are often two or three children in a crib.

The hospital has no delivery service, but conducts an active prenatal clinic whose most important function is immunizing pregnant women with tetanus toxoid. In a woman never previously immunized, three shots of phosphate absorbed tetanus toxoid will prevent tetanus neonatorum in her infant. We give the first two shots a month apart, and the third in the last trimester, but for a woman previously immunized, a booster shot in the last trimester is enough.

Haiti is overpopulated and we are often asked about family planning. We use the Lippes Loop. We began inserting loops in December 1965; by the end of 1966, 250 had been inserted, but we do not have enough nurses to operate even this limited program. Because of the lack of personnel to handle all those interested and because the staff includes many different religions, there must be a firm medical indication (our most common is active tuberculosis), or the patient must be married, or in common-law marriage, have two children, and be a non-Catholic. If the couple is Catholic, we clearly state that birth control is contrary to their religion and send them home to make a decision. If, on a return visit, they still want it, we insert the device. Both the prenatal clinic and the IUD program are handled by a hard-working Dutch midwife, but she cannot be there full-time. Recently, twelve young women with active pulmonary tuberculosis waited several hours in vain for IUD's. We told them they must come back in six weeks, when they would return for their tuberculosis visit. Will they come back? Half of our tuberculosis patients do not keep their appointments.

The only significant administrative problem I have as medical director is keeping the services staffed with physicians. We have a long-term arrangement whereby doctors stay for 18 months, but these commitments are difficult to obtain, and the staff relies heavily on men who can come for

at least a month. Daniel Catlin '36, Hugh Tatlock '38, Homer Lawrence '39, and Howard S. Rubenstein '57 have all worked here under this arrangement.

The medical staff is able and devoted. The international nature of all hospital personnel is exemplified by the current medical staff. On Medicine we have Ben Bonnlander, an American with two years previous experience in Haiti; Dr. and Mrs. Edgar Miller, retired internists from Wilmington, Delaware; Evangelos Apostolou from Greece. On Surgery are Harold May '51; Robert Moe, one of my colleagues from the Truesdale Clinic in Fall River, and myself. On Pediatrics there are Yolanthe Bastiaans, a Dutch Indonesian; Maartin Eerland from the Netherlands; Nora Chang, American trained from Formosa; and Helen Maurer, resident at Cincinnati's Children's Hospital. Gerard Frederique, ophthalmologist; Muller Garnier, anesthesiologist; and Pierre Verna, dentist, all from Haiti.

We have been fortunate over the years to have specialists come to us for a week at a time to clear up problem cases. Thanks to Jerome Adamson of Norfolk, Virginia, we have had a succession of plastic surgeons spend a week with us every six months. For ten years orthopedists James Funk and Robert Wells of Atlanta, and John Golding of Jamaica, have been spending a week every four months. These "orthopedic weeks" are centered around patients brought in by two devoted missionaries who have been in Haiti for twenty-five years. Caroline Bradshaw brings children with Pott's disease from her mission in Port-de-Paix, having prepared them with months of bedrest and anti-tuberculosis drugs. At HAS their para-spinal abscesses are drained, or their spines fused. A week later they go back, without a cast, in a jeep over five hours of bad road for more months of bed and drugs. Patients with chronic orthopedic problems are brought by Sister Joan Margaret from Port-au-Prince.

They are treated and then returned to her rehabilitation and physiotherapy clinic.

The nursing staff of HAS is made up of Haitian, Swiss, Dutch, and Canadian women, and currently only three Americans. Miss Walborg Peterson, whom some may remember as an executive assistant to the director of the Massachusetts Eye and Ear Infirmary, is superintendent of nurses and has been with the hospital since its beginning. "Miss Pete" and Dr. and Mrs. Mellon are the inspiring examples that have kept the hospital running with a light heart and compassionate concern for the sick.

Since 1957 the Mennonite Central Committee has maintained a unit of nurses, pharmacists, laboratory technicians, and community development workers. The Missionary Sisters of the Immaculate Conception from Montreal do the same. One of the sisters is the principal of the school for nurses aides.

One of the sadder activities is the unpleasant business of "screening." Twice daily, standing on the front steps, we are forced to decide whom we can help and whom we must send away, for we have only so many beds, so many doctors and nurses.

But all is not so grim. With these young men and women, from Haiti and the rest of the world, we have a happy and often humorous life—our own variety of an international jet set. A few evenings ago we heard great noise and laughter. In bright tropical moonlight and beneath the flamboyant trees, the Mennonites were celebrating the pharmacist's birthday by throwing him, fully clothed, into the pool. Two weeks ago our house was filled with people who danced until 1:00 A.M. to the music of a five-piece band from Port-au-Prince. We were celebrating Valentine's Day and the birthday of a staff man who was leaving for a month's study at the Pittsburgh Eye and Ear Infirmary.

Dr. and Mrs. Mellon discuss the young patient's condition with his mother.





Une petite belle fille.

II From the Outside

HAITI, occupying the western third of the island of Hispaniola, is the one virtually all-Negro nation of the hemisphere. In some ways it is typical of Latin America, in some ways, of Africa, and in most ways worse than both. According to the 1966 *Information Please Almanac*, "it has the highest illiteracy rate, the deepest poverty, and one of the most meager endowments of natural resources of all the countries in the hemisphere." It is also the most densely populated, with 425 people per square mile. In spite of the fact that most of the land is rocky mountainside, less than ten percent of Haiti's four and one-half million people live in cities or towns with more than 5,000 people. For instance, Cayes, the fourth largest city in the country, has a population of only 15,000.

Haiti has a colorful if not uniformly glorious past. Columbus discovered it on his first voyage in 1492, and epidemics of smallpox essentially decimated the native Indians during the subsequent colonization by the Spanish. In 1697, by the peace of Ryswick, France acquired the western third of the island

and initiated a remarkable period of economic development: sugar, coffee, cocoa, and other products were grown and exported to Europe. Haiti was France's richest overseas possession and by the middle of the 18th century, its annual export and import trade was greater than that of the 13 American colonies combined, or that of all the colonies of Spain combined. This prosperity was based on the cultivation of great plantations by slaves imported from Africa, who labored under the crudest of conditions. When revolution broke out in France, the slaves themselves rose against their masters under a remarkable leader named Toussaint L'Ouverture, and by 1801 had driven out the French and were in control of the country. But, in 1802, Napoleon, who dreamed of using Haiti as a base for seizing the whole North American continent, sent a large army of veterans from the Egyptian campaign under his brother-in-law, General LeClerc. The fierce resistance of the Negroes, and heavy losses from yellow fever, destroyed the French army and its commander. France abandoned its hope of an American empire, left Haiti for the

last time, and sold its Louisiana Territory to the young United States.

There are two clearly defined social classes in Haiti: the peasants and the elite. The elite, no more than three percent of the population, are urban, literate, Roman Catholic, speak French, disdain manual labor, and traditionally control the professions, commerce, and the government. They wear shoes. The peasants till the soil, speak Creole, practice Voodoo, and are 95 percent illiterate. They do not wear shoes. There is also a racial difference between the two groups: the peasants are mostly Negro, and the elite mostly mulatto. This difference originated in colonial times, when many mulattoes became freedmen, and often planters themselves. Though not wealthy by American standards, the elite pride themselves on their cultural refinement and cosmopolitan interests, in which they look to France for leadership. They essentially think of themselves as slightly darker Frenchmen. In recent years political and economic reverses have considerably diluted their power, and many of them have left the country.

The peasants live in much the same fashion as their African ancestors, in one or two-room, dirt-floored, mud-and-wattle, thatched-roof huts, called *cailles*, which are about the size of a one-car garage. The *cailles* are usually found in groups of three or more, constituting a *lacour*, and in the countryside you can find a *lacour* every few hundred yards. Marriage is rare among the peasants; the children belong to, and are often taken care of only by the mothers. The garden plots are minute, frequently less than an acre in size; the soil is very poor and rocky, and productive only with irrigation. The peasants grow corn, millet, yams, sweet potatoes, and several varieties of beans. Lower in the valleys, rice can be grown. The fortunate families may have a banana or a mango tree, and possibly a skinny hog or a few quail-sized chickens. Water is generally carried to the house from a nearby stream or ditch. Very often the young children are left in the care of an older sibling while the parents visit their *jardin*, which may be several hours away.

Travel is extremely difficult. A trip from Haiti's third to its fifth largest city, a distance of 60 miles, took me three and a half hours. No one maintains the roads and even the main routes are often impassable except by jeep or horse, and in the rainy season, almost all roads are completely closed.

The Creole language, used by the peasants, is loosely based on 17th century Norman French. It has a simplified grammar, and has borrowed many words from English, Spanish, and African.

The peasant's chief diversions are cockfighting, and voodoo or *rara* ceremonies. This is not the appropriate place to describe these fascinating subjects, but I will say that voodoo is probably a good deal less sinister and necromantic than is commonly believed in the United States.

The general level of health in Haiti has not improved much since the extermination of the aborigines and the decimation of the French army. Mortality in the first year of life, for instance, is estimated at 50 percent. Principal improvements have been in controlling yaws and malaria. A nationwide campaign in the 1950's essentially eradicated yaws. It was financed by the World Health Organization and directed by Dr. Duvalier, who was then Minister of Health, and is now President of Haiti. Malaria has responded to a similar campaign, but now the funds are running low, and in the future malaria may represent a serious problem. Tetanus is a serious and common

problem. Hookworm, ascariasis, and amebiasis are extremely prevalent, and no one knows how much they contribute to morbidity in the population.

Tuberculosis is a major threat; it is estimated that in the general population 28 per 1000 have active disease. The lack of appropriate facilities and the economic demands of survival often force the carriers to hide their disease and remain, infective, in their communities.

Malnutrition is general. While a frequent problem in adults, its most dramatic presentation is in the children, who show all stages of hypocaloric dwarfism, marasmus, and kwashiorkor.

I spent two days in the pediatric clinic at the hospital, tabulating weight versus age for all the children who came in for any reason. These are plotted on the Gomez scale, devised by Mexican nutritionists for quantifying malnutrition. On these two days, 172 out of 208 children were malnourished, in a more or less bell-shaped distribution.

A frequent concomitant of protein-calorie malnutrition is Vitamin A deficiency, of which the most striking manifestation is keratomalacia, often leading to corneal perforation, and sometimes resulting in blindness. We saw five or six such cases in our one month on the pediatric service.

Any acute illness can precipitate a marginally nourished child into acute protein-calorie or vitamin A failure. We saw many cases where measles had done just this; the child would be brought to the hospital with a recent history of measles, and show fever, pneumonia, dermatitis, conjunctivitis, and a dehydrating gastroenteritis—plus an overlay of nutritional edema and corneal ulceration or perforation. Many of these children died.

The Haitian government has not been capable of doing very much about all these problems. The malaria eradication program is faltering because the government's share—3 percent—has not been paid. There is a medical school in Port-au-Prince, but no instruction in public health is given there. Graduates are required by law to spend a two-year rural residency at one of the government hospitals or infirmaries scattered throughout the country, but in many places these young men have absolutely no equipment, no drugs, no bandages, and even no soap. Understandably, some become discouraged and do poor work or none at all, but a good number persevere and do as well as they can with what they have. There are government hospitals in the major cities, but for the most part, good medical care is available only to the wealthy. Many Haitian doctors emigrate, frequently to Quebec or to the Congo.

There is a thriving folk medicine, intertwined with the voodoo religion, with a hierarchy of witchdoctors. They are, in increasing order of training and skill; the *docteur-feuille* or "leaf-doctor," the *bocor*, and the *houngan*. They are probably the first, and often the only recourse of a sick peasant. It is likely that in some cases, such as bone-setting or psychiatric problems, they do some good. Another important group in every community are the local midwives, who handle most of the deliveries in the country.

What good medical care is available for Haitian peasants comes from the several voluntary mission hospitals set up in various parts of the country by private American groups. Most of these are church-affiliated; the Mennonite Central Committee and the Unevangelized Fields Mission are particularly active. But the most singular and interesting health

facility in the country is l'Hôpital Albert Schweitzer.

Next to the hospital is a sheltered area, and many patients and families who arrive on the evening before they are to be seen, sleep there. Some must travel several days on foot or horseback to get to the hospital. Big clinic days are on Monday, Wednesday, and Friday. Everyone who lives within the hospital district is allowed in, but outdistrict people with emergent problems are never turned away and they sometimes account for half the patient load.

Every patient is seen by a doctor. A token amount of 40¢ is charged for each visit. Treatment and medicines are free, and the hospital also gives out many milk and food packages.

The hospital staff is a varied one: at the time of my visit there were twelve permanent physicians—two internists, two surgeons, three pediatricians, a dentist, an anesthesiologist, and an ophthalmologist; plus Dr. Mellon and Dr. Berggren, of whom I will speak later. In addition, there were eight doctors serving for temporary periods, from a week to a few months. The permanent staff has five Americans, three Haitians, two Dutch, one Greek, and one Chinese. All but the Dutch have had residency training in the States, and most are board certified or qualified. Two are Harvard graduates.

In general, Hôpital Albert Schweitzer operates in about the same manner as a very good community hospital in the United States. It differs in the nature and the number of its patients.

It also differs in its involvement in the community. Dr. Mellon, the founder, soon perceived that the poor state of health was a manifestation of poverty and ignorance, and set out to do something about them. He now spends most of his time with the community development work of the hospital,

in a multitude of areas. For example, the hospital has tried to encourage cottage industry by buying raw and spun cotton, and setting up sewing, weaving, ceramic and carpentry centers where the people can learn a trade and earn a living at the same time. There are several irrigation projects under way, some of them continuations of an American-financed development program in the Valley which was halted in 1962 because of political differences between Port-au-Prince and Washington. The peasants provide their own labor on a food-for-work basis.

An American veterinarian is an important part of this attempt to improve the community's economic strength and its nutrition. He has a clinic near the hospital, and also performs immunizations around the district on hogs, cattle, and beasts of burden. As one might imagine, their health is no better than that of their masters, and often worse.

There are also several other facets in the struggle against ignorance. An elementary school was started in 1962 in Deschapelles which teaches the rudiments of scientific agriculture as well as the three R's. There is an adult literacy campaign. All the midwives in the district are urged to come to the hospital for instruction in sterile technique.

In the field of public health itself, the hospital has begun regular and comprehensive immunization programs at the schools in the district, and the community development workers have piped clean water for drinking into many of the villages.

A clear sign of this shift in the hospital's orientation towards health in the community has been the recent hiring of Dr. Warren L. Berggren as Director of Community Health (the term "public health" is avoided because it suggests a

Gus Menager, Hôpital Agronomie, with his students.



government activity). Dr. Berggren spent five years working in mission hospitals in the remoter areas of the Congo, then went to the Harvard School of Public Health, where he earned an M.P.H. and a Dr.P.H. No one else at HAS had a background in the academic as well as the clinical side of tropical medicine, and it was because of his special training that he was asked to join the staff. No specific problems were selected for him to tackle: the existing community programs had sprung up in areas of need, and therefore, it was left for him to decide which problems to tackle first. After a three-month period of orientation in the community and the hospital, he has marked off some of the areas in which he plans to work.

Malnutrition, which underlies most of the childhood diseases, will be his first target. Despite their poverty, most mothers could feed their children better if they knew more about nutrition; for instance, that breast feeding should go on as long as possible; that certain readily available foods—such as red beans or peanuts—are high in needed proteins and calories; that yellow sweet potatoes (which have more vitamin A) are better than the more popular white ones; and so on. An attempt is made to convey this sort of information in the pediatric clinic, but when the doctor has to see 50 patients a day, he cannot spend very much time on individual instruction. Dr. Berggren is setting a practical demonstration in a *caille* near the hospital, where a Haitian woman with some training in nutrition can prepare a nutritious meal in the mother's presence, using an outdoor fire, familiar utensils, and cheap and available foods.

Furthermore, he plans to set up nutrition centers in villages in the district where mothers can come for longer periods with their undernourished children, and themselves prepare meals, under the guidance of a sympathetic and well-trained native instructor. These would be patterned on a pilot project nutrition center, established near Port-au-Prince by the Haitian Bureau of Nutrition, which has been running successfully for two years.

At present, all information on hospital patients is kept in dossiers. This assures a safe, permanent record, but it does not permit learning about a patient in his home. Dr. Berggren hopes to set up a personal health card system for the children of the community; the cards would record immunizations, clinic visits, home visits, hospitalizations, and chart weight. This too would permit follow-up outside the hospital—at a nutrition center, for example—and make visits to particular localities useful for gathering information. It would also be the key to large-scale, immunization programs. At present, only school children, some pregnant women, and children brought to the hospital get immunized effectively; left untouched are the great bulk of pre-school children who form the population most at risk. The principle of the health card could be extended in the future to women in the child-bearing age, and tuberculosis patients.

A program is underway to evaluate the work done by individual midwives, and to provide incentives for them to improve their standards.

I think there are a number of things to be learned from the changes and adjustments that HAS has made in relation to its community. What began almost as a transplant from the American system of medical care has rapidly taken on a unique and very different aspect. Before I went to Haiti, Dr. Irving Wolman asked me what, in retrospect, became a very central question: "If the hospital disappeared overnight,

would there be any trace of its work in the Valley after five years?" Reflecting on this after being there a while, I could see that the work on the wards and in the clinics, despite its great immediate importance, would have no long-term effects. The things which *do* have a lasting impact are immunizations and, much more importantly, literacy, skills, and health habits and attitudes. In this sense HAS is primarily a teaching institution, with a far more crucial and challenging task than any "teaching" hospital in the United States, for it involves teaching the entire community almost a whole culture-load of things.

Clearly, curative medicine alone in this situation would be practically and scientifically unsatisfactory, while preventive medicine alone would be unsatisfactory in the humane sense. Explaining his own present orientation, Dr. Berggren speaks of his experience in the Congo: "I found that I was getting such a kick out of operating on incarcerated hernias and treating acute disease that I tended to lose sight of the fact that the people down in the village were no better off, and still getting sick from the same things. It seemed to me that if I really cared for those people, I'd be doing something for them down in the village."

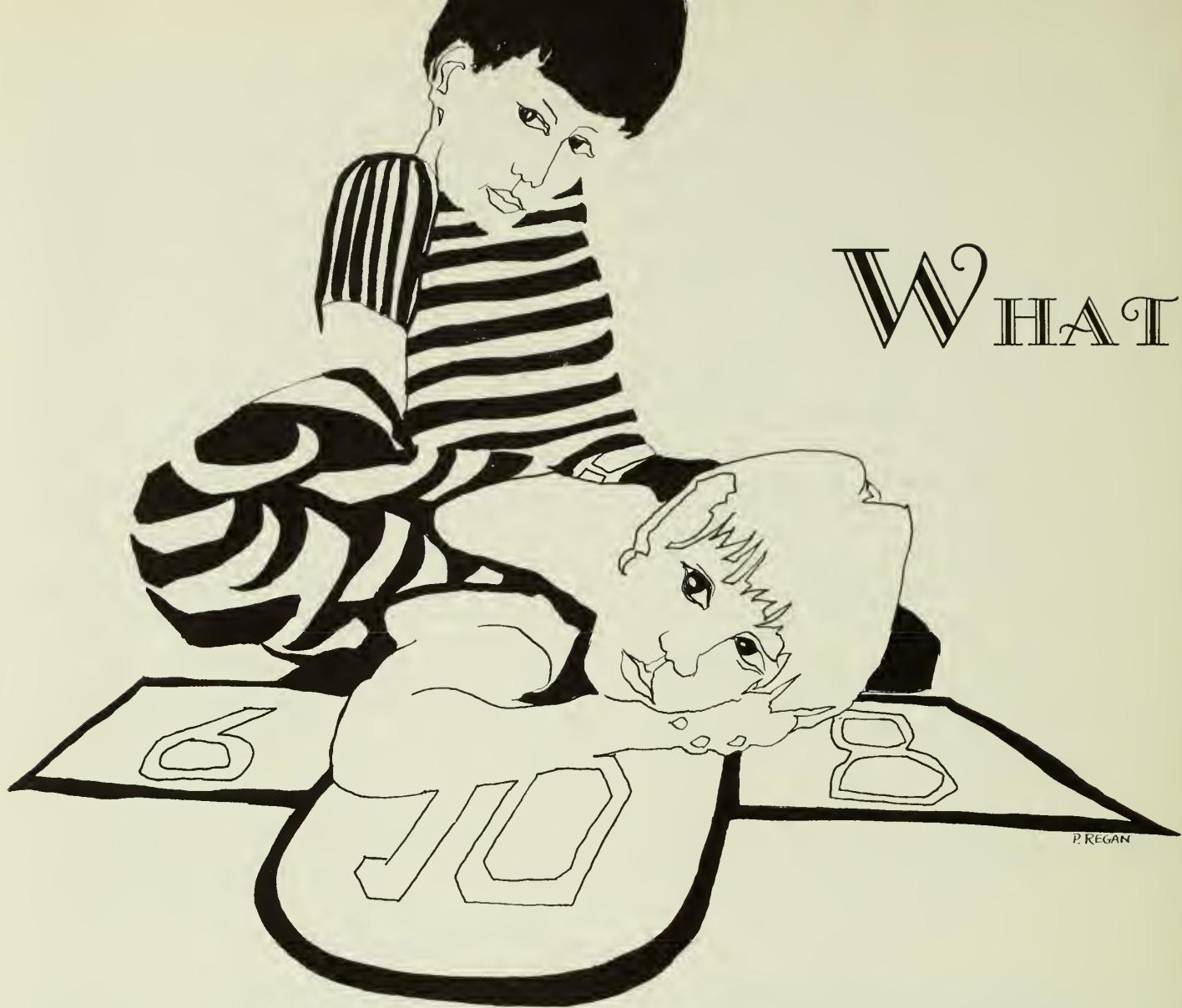
Of course, the optimal solutions call for both curative and preventive skills, and HAS is fortunate in having both. In reality they are two sides of the same coin, but when money is tight, the dilemma of one versus the other always appears. R. G. Hendrickse, a doctor in Nigeria, says of the problem: "In this situation the physician has to decide the most effective way in which to utilize the inadequate resources at his disposal. In essence he has to weigh the relative merits of pursuing curative or preventive medicine. The most persuasive argument in favor of curative efforts is the humanitarian appeal of thousands of sick children who daily besiege clinics and hospitals in urgent need of treatment. The most potent argument in favor of preventive efforts is the certain knowledge that their wide application will, in the long run, reduce much more effectively the overall morbidity and mortality rates."

The forward march of medicine is unquestioned—but its front is never even. The gap between the enzyme chemist and the bush midwife is symbolic of the gap between the medical care available in Boston and that available in rural Haiti. And the gap is increasing. Thomas H. Weller '40, in a recent speech, said, "this is the major task facing mankind, one that is an intellectual challenge of the highest order, and one that can have no higher priority. . . . The scientist contemplating the magnitude of the task can only be humbled by its complexity, be frightened by its compelling urgency, and be frustrated by an appreciation of his personal inadequacies."

I think we are all in the medical field because we feel some sort of calling, because we feel, in some sense, that we are our brothers' keepers, and I think we all have an obligation to ourselves and to our world to examine our plans in the light of the world's needs as well as those of our own.

Gentlemen, the bell is tolling.

Dr. Saxbe spent six weeks at l'Hôpital Albert Schweitzer, under the auspices of the Harvard School of Public Health. His work there was supported in part by a USPHS grant. The above article grew out of his experience in Haiti and has been excerpted from his Boylston Medical Society paper entitled, "The Bell Tolls."



WHAT

by William W. Waring '47

SINCE medicine is essentially a continuous series of health-related personal services, the doctor, as much as anyone, is exposed to a large number of all sorts of people. Each patient has a name, dull or interesting, plain or fancy, one usually chosen by his mother, and frequently assigned on the spur of the post-partum moment.

My own interest in names began in the outpatient department of the Harriet Lane Home, which is the pediatric division of Johns Hopkins Hospital. In 1949, the director of the outpatient clinics was Dr. Barton Childs, the pediatric geneticist. He kept a list of patients' names that amused him, and I regret intensely my inability to recall any of his fine examples. But, I was inspired by his collection, and I too began to jot down sick children's names.

After critically reviewing my list, I decided upon a classification of 14 groups, and I have been able to assign every name to at least one group. The groupings are not necessarily exclusive, however, and many names fall under more than one heading. Charity Hospital has added immeasurably to the length and breadth of my list. I must ask you to take my word on the authenticity of all the names I will use as examples.

The headings of my still incomplete classification are:

Unworkable Family Name
Intrinsic Obscenity
Spurious Elegance
Great Name Associations, with subgroupings;
 Biblical
 Ancient Pagan
 Hollywood
 Presidential
 Uncommon Papal
 Painting
Rhyming Given Names
Transposing Given Names
Geographical Associations
Holiday Associations
Malicious Intern Inspirations
Boomerang Euphonies
Original Alliterations
Coincidental Medical Pertinence
Unfortunate Choice of Given Name with
 Already Unfortunate Family Name
 Combinations

As an example of an Unworkable Family Name, let me suggest Olivia Baloney. There is really nothing wrong with Olivia, except for its suggestion in this association of liver, which only compounds the felonious Baloney.

NAME

A CHILLES ASSUMED . . .

Closely related to the Unworkable Family Name is the category of Unfortunate Choice of Given Name with Already Unfortunate Family Name. Consider the siblingship of Shadell Fluker, Shewanda Fluker, and Inthia Fluker. I would be willing to have you reclassify some or all of these names under Spurious Elegance. No one would argue with my next example: the name Ophelia Puckett is an expiration, if that is the opposite of inspiration. I admit, however, that Ophelia Puckett is also somehow appropriate under the Intrinsic Obscenity heading.

The Great Name Associations are more easily assigned. Under the Ancient Pagan subgrouping we have Deontronese Smith; under the Unusual Papal there is Boniface Furguson; under Biblical there are Ezekiel Wings and Alisha Eddins; and under Painting there is Mona Lisa White, whom I saw last week smiling cryptically after an epileptic attack. Woodrow Wilson III falls neatly under the Presidential grouping.

Under Holiday Association, I can easily place Halloween Buggage, who was obviously born on Halloween. Australia Rivers, you will agree, is clearly a Geographical Association.

I have one family of ten children to cite as a truly classic example of the Rhyming Given Names division: Brenda Loyce Smith, Glenda Joyce Smith, Lenda Royce Smith, Renda Floyce Smith, Flenda Toyce Smith, Zenda Cloyce Smith, Wenda Voyce Smith, Treda Koyce Smith, Kenda Boyce Smith, and Quenda Doyce Smith. These brothers and sisters range in age from 6 weeks to 18 years.

Under the related Transposing Given Names category, I have only Anne Marie Phillips and Marianne Phillips, although I am sure that there exist far better examples.

Now we come to the category of Original Alliterations, the repetition of the same sound in both given and family names, but with particular flair and originality. I proudly cite Geweylond Gray and Congura Coleman.

A frequently more subtle classification is the Boomerang Euphony heading, where a given name is chosen for its pleasant sound, but in fact, suggests or means quite the opposite. There are other examples, but Florine Smith is a good one, inspired no doubt by sweet-smelling Flora, but suggesting instead the foul yellow gas, fluorine. It is names like this that brighten the pediatrician's day.

The most elevated category of all is Coincidental Medical Pertinence in which a name by itself is only a name, but one

that takes on new meaning when associated with the disease of its bearer. The relation of a name and a disease thus becomes a kind of medical parlor game. I must diverge momentarily to set the stage for a pure example of this category. Acute glomerulonephritis is a common disease of the kidneys in which an important sign, hematuria, occurs as a brownish-red color of the urine due to the presence of blood in the voided sample. I recall a child who presented at Johns Hopkins with hematuria due to glomerulonephritis: his name was Rusty Sprinkle.

The final classification is Combinations, under which I put all the names that clearly refuse to fit under a single heading. My first example is a name that goes nicely under Coincidental Medical Pertinence, but also under Malicious Intern Inspiration or Boomerang Euphony, depending upon the author of the name. The term aphonia is applied to those diseases of the larynx associated with loss of the ability to phonate. My patient, Aphonia Mason, arrived literally voiceless due to a laryngeal irritation caused by a metal slug lodged in her pharynx. She can be classified under the Coincidental Medical Pertinence category. But who named her? Was she named euphoniously but boomerangingly by her mother, or was the name the malicious inspiration of an intern when asked to suggest a name for a squalling newborn? In any case, how prophetic the choice!

Demetrus Plick is another combination, classifiable under the Ancient Pagan subgrouping of Great Name Associations, and also under Intrinsic Obscenity for those familiar with the fellow who refused to leave a tip in the Chinese restaurant.

I have only one name left. I have saved it until last because it is one of those selections that only the adjective cataclysmic can characterize. The patient was an infant with truly extraordinary diarrhea. The conjunction of his small size and his giant disease somehow increased the impact made on us by his name. Imagine a name that can be simultaneously classified under the headings of Intrinsic Obscenity, Spurious Elegance, Coincidental Medical Pertinence, Unworkable Family Name, Boomerang Euphony, as well as Unfortunate Choice of Given Name with Already Unfortunate Family Name. When you have racked your brains, and exhausted have given up the effort, I will submit quietly the name of that loose-stooled tot, the all-time winning name of LeGrunt E. Crapper.



ALONG THE PERIMETER

New Leadership for Exciting Enterprise

Mr. Ray Everett Brown, a nationally known authority on hospital administration and health affairs, has been appointed Executive Vice President of the Harvard Affiliated Hospitals Center.

Speaking for the Center and for the representatives of the three affiliated hospitals—the Boston Hospital for Women, the Peter Bent Brigham Hospital, and the Robert Breck Brigham Hospital—AHC president, F. Stanton Deland said that Mr. Brown is "the most qualified administrator that we could bring to this extremely exciting and vital hospital enterprise. We count ourselves extremely fortunate that Mr. Brown consented to relinquish his important responsibilities at Duke University to join with us in Boston. Under his leadership we look forward to a rapid culmination of the Center's objectives."

Mr. Brown directed a hospital complex, similar to the one planned in Boston, from 1945 through 1961 as Superintendent of the University of Chicago Hospitals and Clinics and as Director of the Graduate Program of Hospital Ad-

ministration. In 1961 he became Vice President for Administration at the University of Chicago and continued in that post until 1964 when he became Director of the Graduate Program of Hospital Administration and Professor of Administration at Duke University.

He is the author of *Judgment in Administration* published in 1966 by McGraw-Hill, a book being considered for a national award as the outstanding publication in its field. Of his book, Mr. Brown says, "It is an attempt to examine what unique contributions the executive makes to the administrative process. It differs from other publications on administration in that they describe how the executive fits into the administrative process."

Mr. Brown is a member of the Advisory Committee that is evaluating the Nurse Training Act of 1964; the National Advisory Committee on Hospital Effectiveness; and President Johnson's Review Committee on the Regional Medical Care Programs Act. He holds the Distinguished Service Medal of the American Association of Hospital Plan-

ning, the Distinguished Service Award of the Illinois Hospital Association, and in 1967 he received the Distinguished Service Award from the American Society of Hospital Pharmacists.

In his new position, Mr. Brown will work closely with the three affiliated Boston Hospitals. Since the early 1960's these hospitals have been considering a joint venture to establish a coordinated medical center which would enable each hospital to promote its objectives and discharge its responsibilities more effectively than it could do alone. On June 30, 1967, the hospitals formally signed an agreement to that end.

Mr. Brown will be the chief planning and ultimate operative officer of the Center. He will be responsible, under the Governing Board, for the planning of the common and jointly-used facilities as well as for the coordination of plans of the individual hospital areas.

The affairs of the Center will be supervised and directed by a Governing Board initially composed of the Presidents of the three Hospitals and the President of the Affiliated Hospitals Center. The Center's program for patient care, teaching, and research, and the coordination of medical programs of each constituent Hospital will be under the direction of a Medical Executive Committee. Members of the Committee will include Mr. Brown, the chiefs of Medicine, Surgery, Pathology, and Radiology from the Peter Bent Brigham Hospital, the chiefs of Obstetrics and Gynecology from the Boston Hospital for Women, and the physician-in-chief from the Robert B. Brigham Hospital.

The hospital complex will be built on land presently owned by the Peter Bent Brigham Hospital and on adjoining land. Each hospital will have a separate, identifiable geographic area within the complex combined with a central core area for joint facilities and common services.

Prior to the construction of the central hospital, ancillary facilities—housing for medical personnel and a halfway house for convalescing patients—are planned.

During the planning and construction period, each hospital will retain its own administrative staff and have its own administrative autonomy. As the hospitals move into the complex, Mr. Brown will assume general administrative supervision of each.



Mr. Brown

Professor of Health Law Shared by Two Schools

Dean John C. Snyder '35, of the Harvard School of Public Health and Dean Robert Ebert recently announced the appointment of William J. Curran as Visiting Professor of Health Law of both faculties.

It is expected that Professor Curran will serve in a totally new capacity at the juncture of medicine and law, bringing to each a better understanding of the problems common to both professions. At the same time he will study the areas of social responsibility in which physicians and other health professionals will find themselves increasingly involved in the future.

Professor Curran will work with students of the Medical School and the School of Public Health, and he will also teach a medical-legal seminar at the Harvard Law School.

"There is a need," Professor Curran believes, "for the training of a new kind of medical-legal person—a specialist who can bridge the gap between the two disciplines. Law and medicine should mesh, not clash."

Professor Curran is instituting a collection of written materials at the juncture of medicine and law, including periodicals and international agreements in the field of public health, such as works in sanitation control, air and water pollution.

"We will," he says, "work closely with the World Health Organization and other international groups in building this new collection."

Professor Curran is the former dean-director of Metrocenter and Metropolitan College, Boston University and founder of the Law-Medicine Institute at that University. He was responsible for an extensive educational program involving over 5,000 students in more than 500 courses, institutes and other short-term graduate, undergraduate and continuing educational programs.

In 1950, Professor Curran received the LL.B. degree from Boston College Law School, a year later, the LL.M. degree from Harvard Law School, and in 1958 the S.M. Hygiene degree from the Harvard School of Public Health.

William J. Curran



In 1962 he received a Ford Foundation International Law Faculty Fellowship for independent research in Great Britain concerning the legal, legislative, administrative and economic aspects of the British National Health Service.

Professor Curran is legal counsel for the Medical Foundation, Inc., associate legal counsel for United Health Foundations, Inc., and associate editor for

Medico-Legal Problems.

He was president of the Massachusetts Public Health Association from 1965-1966, chairman of the Committee on Law and Medicine, Association of American Law Schools from 1964-1965, associate professor of law at Boston College from 1953-1957, and in 1952, assistant director of the Institute of Government, U. of North Carolina.

CHMC Gift to Establish Wolbach Chair at HMS

A gift to Harvard University of \$500,000 was recently made by the Children's Hospital Medical Center, Boston, to establish the S. Burt Wolbach Professorship of Pathology in the Faculty of Medicine.

The Professorship honors the memory of Simeon Burt Wolbach '03, a native of Grand Island, Nebraska, who was Shattuck Professor of Pathological Anatomy at HMS from 1922 to 1947 and then professor emeritus until his death in 1954.

In the eyes of his contemporaries, Dr. Wolbach's research contributions were both numerous and significant. His most original studies were in the field of infectious disease, particularly two rickettsial diseases, Rocky Mountain spotted fever and typhus. In 1919 he presented the first accurate description of the etiologic agent of Rocky Mountain spotted fever and described

its clinical symptoms and pathology. His pioneer studies on typhus were carried on in 1920 as a member of the Commission to Poland sent by the League of Red Cross Societies.

The new Chair is the second gift from the Children's Hospital Medical Center (the first, in 1961, being the establishment of the Bronson Crothers Professorship in Neurology). Funds for the Wolbach Professorship were gained by the Children's Hospital Medical Center as part of its \$15,000,000 capital drive "REACH"—Resources of Excellence in the Advancement of Child Health.

Harvard University officials, noting that \$600,000 is now required for an endowed professorship in the Faculty of Medicine, said the income from the gift will be accumulated and added to the principal until the required sum is attained.

Two Associate Professors

Two faculty members were recently promoted to tenure positions as associate professors: Morton N. Swartz '47, now associate professor of medicine at the Massachusetts General Hospital, and John Hedley-Whyte, associate professor of anesthesia at the Beth Israel Hospital.



Dr. Swartz

Dr. Swartz' association with the MGH began when he was an intern and resident there and it has continued ever since with only three interruptions. In 1951-1953 he became Captain (M.C.) in the U.S. Army with the 35th Field Artillery in Germany. In 1954-1956 he went to the McCollum Pratt Institute of the Johns Hopkins University as a postdoctoral research fellow (USPHS) in biochemistry. While there he first worked with Dr. Nathan O. Kaplan—who is now at Brandeis University—and the two men collaborated in producing a number of sophisticated papers on the significance and mechanism of heatactivation of enzymes of the diphosphopyridine nucleotide class. Then in 1960-1961, Dr. Swartz took a sabbatical year which he spent at the biochemistry department of Stanford University School of Medicine in the laboratory of Dr. Arthur Kornberg.

In 1956, Dr. Swartz became chief of the Infectious Disease Unit at the MGH, and since then the Unit has become recognized as a model for its consulting service in patient care and its teaching service for the medical house staff and students.

In the past few years his research activities have focused on the structure and enzymatic synthesis of deoxyribonucleic acid, DNA, particularly of bacterial and viral origin. Thus Dr. Swartz is able to consider treatment of clinical infections in terms of the possible molecular action of antibiotics. His research in association with both Dr. Kaplan and Dr. Kornberg has resulted in a better understanding of the relationship between biochemistry of microbial systems and clinical bacterial infections.

Dr. Hedley-Whyte's association with the Massachusetts General Hospital, and in fact with the United States, began seven years ago when he arrived from England to become clinical fellow, and acting assistant resident in anesthesia at the MGH. In 1961, Dr. Hedley-Whyte became assistant in anesthesia for Harvard Medical School, instructor two years later, and in 1965, clinical associate. In 1964 he became a diplomate of the American Board of Anesthesiology and fellow of the American College of Anesthesiology.

Dr. Hedley-Whyte was born in Newcastle, England. He was educated at Harrow and Cambridge University, receiving his B.A., M.A., and M.D. degrees from that University. His clinical training in surgery was done at St. Bartholomew's Hospital, London, and after becoming senior house surgeon he turned to the field of anesthesiology. He completed his training in this field at the MGH, where he

displayed a considerable interest in and knowledge of pulmonary physiology. Dr. Hedley-Whyte has since made some valuable contributions in the basic area of temperature correction for blood-gas measurements, in the field of blood-gas exchange during and after open heart operations, and in the



Dr. Hedley-Whyte

area of pulmonary mechanics. At the present time he is pursuing certain problems of pulmonary lipoprotein chemistry and pulmonary surface tension in various disease states. He is regarded by both colleagues and students as a gifted teacher.

Dr. Hedley-Whyte is now anesthesiologist-in-chief at BIIH.

Ingraham Professorship

Franc D. Ingraham '25, who died in December 1965, was known as a pioneer in the development of pediatric neurosurgery. He was also considered to be an inspired and inspiring teacher who had the great gift of being able to attract and stimulate others to work in his field. Now a new Chair, to be known as the Franc D. Ingraham Professorship in Neurological Surgery has been established by Harvard University through funds contributed by a group of anonymous donors to the Children's Hospital Medical Center.

The incumbent, as yet unnamed, will serve at both the Children's Hospital and the Peter Bent Brigham Hospital.

Surdna Gift

The Surdna Foundation Inc., of New York recently made a gift of \$1 million to Harvard University. This gift has enabled the University to establish a new professorship in the Faculty of Medicine and has added substantially to the John E. Andrus Teaching and Research Fund, founded in 1962.

Dean Robert H. Ebert announced that \$600,000 will be used to establish, in the Children's Hospital Medical Center, Boston, the Julia Dyckman Andrus Professorship of Pediatrics, in memory of the wife of the late John E. Andrus. The remaining \$400,000 will be added to the John E. Andrus Teaching and Research Fund, bringing the Fund's total endowment to \$1,800,000.

Collaboration 1967 Style

Harvard University and the Massachusetts Institute of Technology recently announced a joint program to (1) seek new opportunities for collaborating in basic and applied research, education and medical care, and (2) with the objective of a continuing improvement in our national health, to explore the most effective use of each institution's complementary resources in the life and health sciences.

Under the aegis of President Nathan M. Pusey and President Howard W. Johnson of M.I.T. a Joint Liaison Committee of Engineering and Living Systems has been established. Members of that Committee are:

From the Massachusetts Institute of Technology—Provost Jerome B. Wiesner; Gordon S. Brown, dean of engineering; Irwin Sizer, dean of the graduate school; Walter A. Rosenblith, professor of communication biophysics; Dr. Albert O. Seeler, medical director and head of the medical department; and Murray Eden, professor of electrical engineering.

From Harvard University—Dean Robert H. Ebert; Dr. Alexander Leaf, Jackson Professor of Clinical Medicine; Elkan R. Blout, Edward S. Harkness Professor of Biological Chemistry; Harvey Brooks, Dean, engineering and applied physics, Faculty of Arts and Sciences; and Dr. David D. Rutstein '34, Ridley Watts Professor of Preventive Medicine. Philip A. Drinker, who holds appointments at both institutions, serves as Secretary.

Three subcommittees have also been organized with membership from the faculties of both institutions to explore each of the focal areas in the fields of medicine and health—research, education and medical care. Dr. Rutstein and Professor Eden, who are responsible for the overall coordination within the Joint Liaison Committee, also serve as members of all three subcommittees.

President Pusey noted that medicine has turned more and more to biochemistry and molecular biology to provide the basic knowledge upon which many recent major medical advances have been achieved, and now advantage must also be taken of the potential contributions of the physical and engineering sciences and mathematics.

The task is to realize the benefits of

science. President Johnson pointed this out when he said, "Rising from the scientific base the super-structure of technology relates to the imaginative and economic application of ideas to human needs. . . . We must find ways to place new emphasis and attention on the systemic nature of large-scale human uses of technology. I mean by this that in this next period of history we must make a special effort to meet in a systematic way the massive needs of our society. This human focus of technology should be a primary concern for today and for the future."

A major objective of this joint effort of Harvard and M.I.T. is to use fully the depth of resources of both institutions and draw upon the vast store of information and facilities in the physical and engineering sciences and mathematics and the extensive resources in the areas of medicine and biology.

Collaboration between the two institutions will include the following:

1. Medical care, the application of systems analysis, operations research and new management theory for more effective use of resources in the functioning of such medical institutions as hospitals; more efficient delivery of medical care to, for example, an urban population, particularly within the city. This approach could serve to identify and eventually to close gaps in the administration of medical care in regional areas that involve urban, suburban and rural populations. These complementary activities will aid in the solution of local health and medical problems, but are to be specifically designed to establish models with nationwide usefulness.

2. To take advantage of the newer technology and apply it for the improvement of medical care as in the use of computer-controlled automation to increase the efficiency and precision of such hospital functions as laboratory testing and drug administration. Automation will also simplify the physician's diagnosis of disease through the development of new analytic instruments for the measurement of body functions.

3. The development of machines physically attached to, and immediately concerned with the life or the health of the patient. These may be in the

form of an artificial organ, such as a kidney or a heart, to tide the patient over an acute episode of failure of a vital organ; a feed-back mechanism for automatic control of such essential human physiologic functions as blood pressure; an electronic prosthesis to help paraplegic patients to walk, or a sensory aid to help the blind to read.

4. An educational program for undergraduate, graduate and postdoctoral students to enable them to become qualified in both the medical and engineering sciences, or to become qualified in one field and conversant with the other.

5. Conduct basic scientific research to weave together the benefits of the physical and engineering sciences, mathematics and technology on the one hand, and medicine and biology on the other.

This is not, of course, the first time Harvard and M.I.T. have collaborated with one another. There have been many examples throughout the years, but perhaps the first occurred in 1913, when, for eight years, there existed under joint management a Harvard—Massachusetts Institute of Technology School for Health Officers. This venture was eventually superseded by the endowment of the Harvard School of Public Health. Among some more recent examples of joint efforts are:

The study of neural mechanisms of hearing at the Massachusetts Eye and Ear Infirmary's Eaton Peabody Laboratory.

The development of more efficient membranes to use in such devices as the artificial kidney or in heart-lung machines.

Studies to define the nature of medical diagnosis and the use of computer technology to aid the physician in this task.

The two institutions have also collaborated in the teaching of biomathematics by professors in the department of electrical engineering at M.I.T. to medical undergraduates in the department of preventive medicine at the Harvard Medical School.

It would be hard to overemphasize, or even predict, the important discoveries that may come from the success of this new collaborative program.

Mental Health on the Forty-third Floor

A college mental health center located in a 52-story metropolitan office building and available to over 100,000 persons 24 hours a day every day of the year, sounds like a projection into the super age of the next century.

But there is such a center. It has been in operation since September 1966, and since January 1967, it has been housed on the 43rd floor of Boston's new Prudential Center. "The College Center" serves the student-faculty mental health needs of some fifty Metropolitan Boston area colleges. The essence of such a facility—a cooperative venture by means of pooling the financial resources of many small colleges—was first conceived a decade ago by Dana L. Farnsworth '33, head of the Harvard University Health Services, in his book, *Mental Health in College and University*.

The Center offers all the generally accepted mental health treatment services: education and prevention, diagnosis and consultation, therapy, and relative anonymity to those seeking aid. It does not offer psychoanalysis and inpatient care.

The financial arrangement of the nonprofit Center with member colleges is presently on a basis of an administrative charge of \$1 per student per year, plus billing for actual services provided at the going rate for private psychiatrists.

"Plans are being made for research to study the problems of colleges as well as the problems of the college students," said Philip Solomon '30, president of the College Center, and senior author of a paper describing the Center's activities which he gave at the Annual Meeting of the American College of Psychiatry in Detroit.

"If the growth of the Center is normal," said Dr. Solomon, "within two or three years the College Center should become a training center for mental health professionals specializing in college psychiatry."

Plutonium Power Implanted

The implantation of a plutonium capsule that could power an artificial heart for as long as ten years has been successfully conducted by John C. Norman, Jr. '54, associate in surgery and assisting surgeon at the Boston City Hospital, and his colleagues.

Working with two dogs, the team placed in each a plutonium power plant weighing only 15 oz. and about the size of a silver dollar, with a 16-thermal-watt fuel disk hermetically sealed in a helium atmosphere and enclosed in an insulated aluminum carrier-conductor embedded in Silastic.

It was noted that the temperature of the dogs rose only one degree above normal and their rate of breathing increased moderately. One of the dogs was sacrificed a week after implantation, and the autopsy showed that the tissues appeared normal. The second dog has, at this writing, carried its

capsule for two weeks.

In the first dog, the capsule was attached to the abdominal artery by a stainless steel tube through which flowed the total volume of the animal's circulating blood. The stainless steel tube around the capsule is designed to protect the capsule from corrosion and draw initial heat emanations into the insulated carrier-conductor.

Dr. Norman said, "We expect the circulating blood to act as a heat transfer medium, and the lungs and body surface to perform as a heat-exchange dissipator." These initial tests are "an encouraging aspect of our overall circulatory-assist investigation."

The Boston City Hospital team, working on this project in conjunction with the Children's Hospital Medical Center, is concerned now to find out what will be the long-range effects of unshielded gamma and neutron irradiation.



CORRECTION: In the Summer issue of HMAB, the article on page 52, "Medical Area Health Service," should have been credited to Samuel Bojar, M.D. as well as to James J. Feeney '52.

BULLETIN

Harvard Medical School Alumni Association



VANDERBILT HALL

June, 1927

PUBLISHED BY THE HARVARD MEDICAL SCHOOL ALUMNI ASSOCIATION
BOSTON, MASS.

A Good Year To Own Bonds

THE enormous wealth which has accumulated in this country has developed an optimism that is recorded in the great up-swing of the post-war investment markets. It has generated a speculative attitude that will have to be reckoned with in due course.

Instinctively, the investor of long experience places a considerable part of his funds in sound bonds at such a time. He seeks to safeguard his principal and yet secure a dependable flow of income.

PROFESSIONAL MEN, absorbed in specialized activities, have reason to be extremely prudent when the veteran investor is showing obvious signs of caution.

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BULLETIN OF THE HARVARD MEDICAL SCHOOL ALUMNI ASSOCIATION

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Publication Office: Room 407, 126 Massachusetts Avenue, Boston

Volume 1

JUNE, 1927

Number 2

VANDERBILT HALL IS RAPIDLY NEARING COMPLETION

As we go to press, the progress of the building construction has reached an advanced stage. The exterior is completed; the windows are all set and the outside staging has been stripped off. Grading of the land is all that remains. Inside, the upper floors with the bedrooms and studies have been plastered and the woodwork, including chair rails, mouldings, mantelpieces and window frames is being installed. To lay the oak floors and hang the doors are the two items of any importance which remain to be accomplished. Downstairs, the work is less advanced. The gymnasium ceiling is being plastered and the yellow glazed brick which covers the walls is almost all laid. The tile floor and dado of the kitchen is about half in, and most of the larger utensils such as ice boxes, refrigerating apparatus, ovens and hoods are in place.

The living room, the dining hall, the library, the office and the students' so-

ciety room are still unfinished, but as the plasterers, carpenters, plumbers, and painters are released from the upper floors, work on this important, but for a moment less essential part of the building goes on at an increasing rate, which means that this too will be completed on time.

No one who has seen this building can fail to be impressed by its imposing exterior, the attractive, comfortable arrangement of the living quarters, and in addition the magnificent extra features such as the Bowditch Dining Hall and the Vanderbilt Gymnasium.

ANNUAL MEETING

The annual meeting of the Harvard Medical School Alumni Association will be held, as usual on Wednesday, the day of the Yale baseball game at Cambridge. This year the date is June 22. The meeting will be held at noon at the Medical School, followed by a buffet luncheon. There will probably be an opportunity to inspect the Dormitory which we have sponsored.

EDITORIAL

The inaugural number of the *Bulletin of the Harvard Medical School Alumni Association* finally appeared in April after many trials and tribulations incident to its conception, and was sent free of cost to every member of the Association. In each copy of the 4,000 odd bulletins sent out, a return postal card was enclosed, asking for an expression of opinion concerning the bulletin, news items of interest, and changes of address. The last item appears to us to be of particular importance, for no association can reach all of its members adequately if it does not know where they are to be located. These changes of address as they have appeared have been filed with the Harvard Alumni Directory, now in Lehman Hall, Cambridge, which keeps up to date, so far as is possible, our lists as well as those of the rest of the University Alumni.

Of these 4300 members of our association who have been reached by the *Bulletin*, something over 600 took the trouble to fill out their post cards and return them to us. The remainder, we presume, were consigned to the waste paper basket possibly with the *Bulletins* containing them. One man who replied expressed disapproval of the *Bulletin*, entirely on the grounds, apparently, that he did not have time to read it. All the rest were glad to receive it and interested in its contents, on their own statements. So many notes concerning alumni were received that it has not been possible to publish them all in this, our second issue.

A few men found postal cards inadequate to express their opinions of our attempt, and wrote letters telling us what they thought of it. Criticisms and suggestions are more valuable than unqualified approval, and some of these letters follow. Names have been omit-

ted as no regular correspondence column has yet been instituted. In succeeding numbers we hope that alumni will write for publication and open these columns to stimulating and perhaps valuable discussions.

"The post card enclosed with the Inaugural Number of the *Harvard Medical School Alumni Association Bulletin* scarcely afforded me sufficient space to express my pleasure and interest in this new project. I have felt very keenly the lack of contact with the Medical School which most of us alumni have. This was brought home to me the more forcibly at the time funds were solicited for the new dormitory. I am sure that outside of the exceptional alumnus who visits the school occasionally and the alumni living in and around Boston the great majority of us have felt that we had no active connection with the Medical School since receiving our degrees and that the Alumni Association meant little, if anything, to us.

"Your prospectus looks good. We would be interested in keeping in touch with activities at the Medical School. We want to know all we can of the problems engaging the experts as well as news of recent discoveries. Items of interest relating to various alumni will be welcomed, I know, by all of us as I am convinced we all too soon become overwhelmed by the duties of our professional work at the expense of many friendships of earlier days.

"I consider it a very fortunate discovery made by the New Dormitory Campaign Committee in its effort to solicit funds from the Alumni. May I suggest that an attempt be made systematically to unearth some of the facts relating to our Alumni by utilizing State and County Medical Societies or, where such exists, the different class organiza-

tions as sources of information. I believe the harvest will more than justify the labor."

"I vigorously concur with Pres. Lowell's note. Something of the nature of the *Bulletin* is needed and very much needed to secure a sustained interest in the affairs and the progress of the Harvard Medical School. Medical schools I believe are created and endowed to secure a class of practitioners engaged in very active work in distant localities far removed from medical centers. Many of us have come to feel that we are widely removed and comparatively isolated from the sources where we secured our early medical training.

"I am classed as decidedly one of the older graduates from the old North Grove Street Building where I sat under such incomparable teachers as H. P. Bowditch, Oliver Wendell Holmes, Henry J. Bigelow, Prof. Minot, Prof. Reynolds and other eminent teachers. I entered active practice fall of 1882 and I have remained continuously in active practice from then until now."

"The first issue of the *Bulletin* has just been received. There has been no tie to bind alumni to the school except through memories and friendships formed there, but I feel sure that the *Bulletin* will serve this purpose. The alumni will substantially support it without question.

"The *Bulletin* can mirror the progress of the school to the alumni at a distance. The dormitory project has had a most stimulating effect. There are, of course, many other needs of the school which the *Bulletin* will be called upon to champion as time goes on. That it will be the ideal agent for such work seems certain.

"I read with great interest the article by Dr. Cannon. I think the historical

and reminiscent note will add greatly to the interest of alumni in the *Bulletin*."

"The Inaugural Number of the *Bulletin* has been received.

"It is most welcome, and I can not see how any alumnus of the Harvard Medical School can fail to find it helpful. If, at some favorable time in the future, a special effort could be made to induce the Alumni to visit the Medical School, I believe a great deal would be accomplished. For example, a regular "get together" meeting with a very active notification campaign might do. Certainly, a very large number of graduates are within striking distance of Boston, and if a program were arranged which would inform them in an interesting manner of the present status of the school's work, and its plans for the future, I believe a large attendance could be secured. Certainly, the *Bulletin* paves the way by establishing a broad liaison between the school and its alumni.

"I realize that there is nothing new in this suggestion, but I make it because I probably am one of a large number who have the opportunity to attend meetings at the school, and yet do not do so for lack of sufficiently strong stimulus."

"I should have written to you before to congratulate you on the fine number of this *Bulletin*. It is a production that has been long needed, and I wish you abundant success in its continuance.

"I shall file all the numbers carefully away until I have volumes No. 25, or perhaps over thirty years, such as the Mayo Clinics. It will be fine to refer to in advancing age."

"The issue of such a publication meets with my hearty approval, and I

believe it should do a lot towards cementing Harvard Medical School alumni. I read it with a great deal of interest, and I believe that similar issues in the future will provide many points of information and interest even for those who are here in Boston all the time.

"It occurred to me, as I read it, that it might be of interest to republish the curve of distribution of Harvard Medical School graduates which was recently published in the Harvard Bulletin, or at least something similar to that for the Medical School, perhaps brought up to the present.

"I also wondered whether it would be advisable to publish from time to time lists of the teaching staffs at the Medical School in various departments, because I believe that probably many of us, even here in Boston, are not familiar with the members of the various departments."

An undergraduate news publication once published the following: "Notice. Hereafter the east walk of the campus

will be reserved for upperclassmen and the west walk for freshmen. This tradition goes into effect next Monday morning." So quickly do traditions become effective in this progressive land that we have some hopes of your *Bulletin* being already a tradition in your minds.

The *Bulletin* has a distinct and definite purpose—that of bringing the Harvard Medical School closer to its alumni and the alumni closer to the school. No set policies have yet been established and it is fitting that they should not be established so early in its infancy. It is your *Bulletin*—you should have a hand in deciding what sort of a bulletin it should be. At all events an attempt will be made to bring to you news of the school and with your co-operation news of the individual members will be presented. Remember also that this will be a medium of exchange for information; class secretaries and others should find it of value for their notices.

Under existing conditions every Alumnus of the Harvard Medical School is automatically a member of the Alumni



Vanderbilt Hall, April, 1927

Association, although still a very small group only is contributing to its support. Nevertheless all receive the *Bulletin*. It is our hope that greater numbers will be stimulated to take an interest in their Medical Alma Mater and become members of the association in fact as well as in name. In the future

we trust—and this will depend somewhat on the support that is accorded us—that regular dates for publication will be assured. This year, commencing in the Spring, two numbers have appeared. For the ensuing year it will be our aim to appear as a quarterly publication.

THE NEW ROCHESTER MEDICAL GROUP

By Nathaniel W. Faxon, M.D., '05

The new medical group recently opened in Rochester, New York, consists of the School of Medicine and Dentistry of The University of Rochester, the Strong Memorial Hospital and the Rochester Municipal Hospital. This group is unusual in several ways. The combination of a medical school, a university hospital and a municipal hospital literally housed under one roof is unique in itself.

The teaching faculty of the School serves as the clinical staff of both hospitals. The intern and nursing service of the two hospitals is identical. Operating rooms, the X-ray department, the physiotherapy department, kitchen, laundry, store room and shops are shared in common, preventing unnecessary duplication of costly equipment. Together these hospitals offer exceptional facilities for the care of patients, the study of disease and the teaching medium to students; of nursing procedure to nurses and of public health to the community.

The Strong Memorial Hospital together with the School of Medicine and Dentistry occupy the large central building of the medical group. A fund of nine million dollars was given in 1920 by George Eastman and the General Education Board for the founding of a School of Medicine and Dentistry, and

an additional million dollars by Mrs. Gertrude Strong Acilles and Mrs. Helen Strong Carter for the erection of a hospital in memory of their father and mother.

As soon as these gifts were announced, steps were taken by the City Government and the University towards the association of the recently planned Municipal Hospital with this new medical group. This resulted in an agreement between the University and the City whereby the city built the new Municipal Hospital adjacent to and joining the Strong Memorial Hospital. The University provides for all medical care of patients and is allowed to carry on teaching in the Municipal Hospital. Nursing and intern service and many of the usual hospital facilities are carried on in common and the expense shared. A spirit of co-operation is written throughout this document.

There are twenty-six private rooms.

The Municipal Hospital adjoins the Strong Memorial Hospital and is connected with it on all floors. Additional divisions are here provided for medical, surgical and obstetrical patients and two special divisions for the care of contagious diseases; one for children and one for adults. Sixteen single rooms have been suitably equipped for the study and care of psychiatric patients,

filling a long felt want in this community. Altogether the Municipal Hospital will accommodate 225 patients. Together the Strong Memorial Hospital and the Municipal Hospital can admit 471 patients; in time of need, these accommodations could be expanded.

Operating rooms, a large X-ray Department, a Physiotherapy Department and a special Metabolism Unit, a central kitchen and laundry, all situated in the Strong Memorial Hospital, are shared jointly by the two institutions. Besides the usual clinical hospital laboratories, the extensive laboratory facilities of the School of Medicine are also available.

The Staff House is connected by covered passageway with the main building and the Municipal Hospital. It provides accommodation for both the clinical staff of Residents, Assistant Residents and Interns in Medicine, Surgery, Obstetrics and Pediatrics, now numbering 26, and the pre-clinical staff of Assistants, Instructors and Residents in Pathology, Bacteriology, Chemistry, Physiology and Anatomy, numbering 11. Four members of the hospital administration also live here. Rooms are provided for men having visiting fellowships. In all there are 56 rooms.

ADMISSION OF PATIENTS

The principle under which the Strong Memorial Hospital will be operated is that of providing hospital care at cost. In so far as possible, only such patients will be admitted to this Hospital as are able to pay this charge. Free patients or those paying less than cost will be admitted to the Municipal Hospital and the deficit will be made up from general taxation. It is hoped that this will appeal to that large part of every community that desires to pay its just obligations and that in this way the best in medical and hospital care may be made available to the "middle class" without the ob-

jectional association of charity where charity is neither needed nor desired. By this method all classes of the community are served. Private rooms are provided for those who can and wish to pay for such service. A medical fee is charged to such patients. Hospital care is furnished at cost to those who cannot bear such medical fees. In the Municipal Hospital those who can neither bear the burden of a medical fee nor pay in full their hospital care, are given the same care as both of the other classes receive.

The library of the Medical School now numbers over 30,000 volumes and is rapidly growing. The use of the library will be extended to all physicians, dentists and scientific workers. The library is open from 9:00 A. M. to 9:00 P. M. daily excepting Sundays and holidays.

The Strong Memorial Hospital opened on January 4, 1926. The first patient was examined on that day and admitted to the Hospital on January 5. By October 1, 1926, 1645 patients had been admitted to the Hospital. The highest number of patients in the Hospital was 116 on September twenty-ninth. The present available bed capacity is 216.

The Out-Patient Department opened upon February 15, 1926, and up to October 1, 1926, 2098 patients had been admitted, examined and treated, totaling 6703 visits.

The Municipal Hospital opened upon July 28, 1926, and between that day and October 1, 1926, 63 patients with contagious diseases had been admitted. The highest number of patients in the Hospital was 27 on September twenty-first. The present available bed capacity is 46.

The combining of the Strong Memorial Hospital, the Municipal Hospital and the School of Medicine and Dentistry has meant an initial financial saving

to the community approximating half a million dollars. It offers unusual opportunities for the efficient care of the sick, the study of disease, and the promotion

of public health. It is unique in vision and in form; an example of co-operation between a great university and a progressive city government.

THE CLASS OF 1902 OF THE HARVARD MEDICAL SCHOOL

Twenty-Fifth Anniversary Report

The Class of 1902 of the Harvard Medical School will celebrate this summer the twenty-fifth anniversary of its graduation. On Saturday, July 9th a reunion will be held at the Country Club Brookline, beginning at luncheon and continuing with varied activities through the afternoon and evening.

At this time, therefore, it may be of interest to report in brief a history of the Class up to the present.

We entered in the fall of 1898 at the old Medical School building on the corner of Boylston and Exeter Streets, and were enrolled under the old requirements for admission which did not include college work. In comment upon the requirements since added it may be said that although the graduates of Harvard, Yale, Brown, Dartmouth and other colleges were as a whole more mature and better able to adjust themselves promptly to the work, still the distinction between college and non-college men was seldom thought of, and many non-college men stood high in their courses and have, since graduation, reached attainments of which the School may well be proud.

Our class was the last one to receive Professor Bowditch's lectures in Physiology, and the first one to have Bacteriology as a regular course in second year. Embryology, because of some administrative difficulty, was not given to our class so that our careers have been pursued in ignorance of this subject. But

while there have been many changes in the curriculum since our day, and certain subjects, notably chemistry and public health, have been amplified greatly, the instruction which we received had already advanced considerably toward its present form. In clinical work there was less opportunity to study in hospital wards and less latitude in the choice of electives than now, but excellent instruction in sections for practical work in clinics was given in nearly all departments.

Perhaps the most conspicuous difference between our time and the present lay in the fact that there were no effectual regulations against absence from courses. Thus even in second and third years many of us would take occasional months of duty in out-patient departments, and in fourth year many were already house officers. These last, by virtue of borrowed notes, would return and pass the examinations although they had never seen the instructors of any courses.

As this indicates, examinations rather than daily work were the basis upon which we passed or failed. And as a result of this there flourished an institution, now obsolete, known as the private "quiz." Students in groups of ten would arrange to go to the home of a junior instructor on one evening in each week for reviews of a certain course. Drs. Tenney and Lothrop gave popular courses in anatomy, Dr. Magrath in pathology, and Dr. Richard Cabot in

medicine and neurology. While these quizzes were taken frankly as preparations for examinations, they were nevertheless of real educational value in interpreting and in bringing out the essentials of their subjects. They also necessitated systematic, concentrated study, week by week, in preparation for each meeting. While the method may now seem primitive, it was extremely effectual.

Our Class organization, from its inception to the present, has maintained its activity. In first year, Harry Bowditch was elected President, and the writer of these notes was made Secretary. On graduation these officers were made permanent, and Jim Torbert was elected Treasurer. In addition, to serve with these, a Class Committee was formed of the following: Donaldson, Goodall, Kent, McCoy, Moore, Quinby and Vincent.

Although since graduation our members have scattered widely, reunions have been held regularly every three years since 1902, except that in 1925 it was decided to defer the meeting until the now approaching occasion.

Credit for holding the Class together so well is due largely to Bradford Kent, lately deceased, whose genius for organization and whose interest in keeping in personal touch with nearly all members made it possible to secure large attendance at all meetings.

The Class has sustained losses, inevitable with the lapse of years but none the less deeply felt, as follows:

George L. Baker
 Allan F. Barnes
 J. Lyman Belknap
 Henry I. Bowditch
 William H. Buffum
 Arthur M. Clapp
 Louis A. Crocker
 Frederick J. Goodridge
 John J. Irving

Bradford Kent
 John A. McCormick
 John J. Mitchell
 Patrick W. Murphy
 Daniel A. O'Hearn
 Albert J. Roberts
 William E. Walker
 Robert A. Whitford
 Louis T. Wilson

The list of surviving members shows that, while the great majority are resident in New England, there are many in more distant parts of the Country, including Ellis in Portland, Oregon, Feiss and Furrer in Cleveland, Hodges in Indianapolis, Hollister in Omaha, Hooker in Seattle, Lilley in Butte, Montana, Mills in Los Angeles and Robinson in Santa Barbara.

Hathaway and Neilson have served long and well in the Navy, and Nute in the Public Health Service.

Dore and Thomas have been abroad in religious or missionary service but both are now again in this Country.

In the Boston group, the following are or have been officers of instruction in the Harvard Medical School: Bowditch, DeNormandie, Emmons, Garland, Goodall, Greenwood, Henderson, Palfrey, Quinby, "Ham" Rice, Richardson, Torbert, Tyzzer, Vincent. The following are teaching in other medical schools or colleges in or near Boston: Dore, Evans, Greene, Thorndike. Commissioner Mahoney represents the Class in the Boston Health Department. Emmons has lately left Boston to assume duties with the American Public Health Association.

Worcester has claimed Belding, Doray, George and E. L. Hunt. In Providence, Barrows, Ferguson and Hammond are worthy members of the strong Harvard group in that city, from which Buffum, who died in Naval service during the War, is sadly missed. In six other cities there are two members of the Class in each, and the Class is represented by one in many of the cities and towns of New England from Maine to Connecticut.

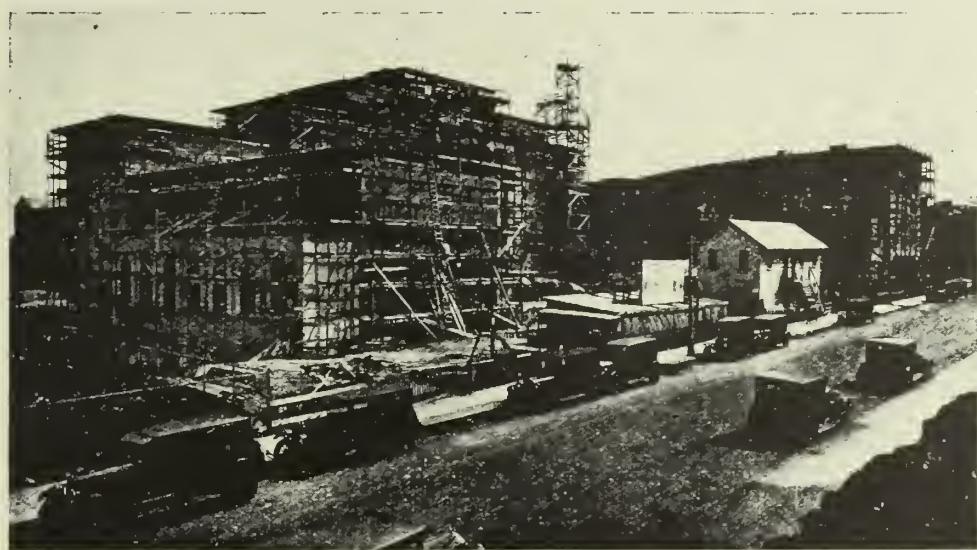
In New York City are Darling, Dennett, Feldstein, Gushee, McPherson and Robbins. Keene is Professor of Hygiene at the University of Buffalo.

Forty-three members of the Class served as officers during the War.

A general survey of the individual careers shows that while a certain number, notably Henderson, Tyzzer and Greene, have devoted themselves mainly to research, others to institutional work or to organized service, and a few to non-medical affairs, the great majority are engaged in the active practice of medicine and surgery in their respective

communities. Now, after twenty-five years have elapsed since their graduation, a creditable proportion have attained eminence. But perhaps even more to the honor of the Harvard Medical School is the total service of the many who are carrying on, wherever they have established themselves, the necessary work of the Medical Profession according to Harvard traditions.

FRANCIS W. PALFREY. *Secretary.*



Vanderbilt Hall from Longwood Avenue, April 1927

HARVARD MEDICAL SCHOOL NEWS ITEMS

Dean Edsall returned to the Medical School in February after a six months' leave of absence. He has been at the Peking Union Medical College as visiting Professor of Medicine, and making some general surveys of the School.

Dr. Charles L. Connor, of the Department of Pathology, Harvard Medical School, was loaned September 1, 1926, to McGill University and the Montreal General Hospital in order to relieve the emergency caused by the illness of Dr. Lawrence J. Rhea. Dr. Connor is Assistant in Pathology and Director of the

Laboratories of the Montreal General Hospital. Owing to the richness of the pathological material the year will be greatly to Dr. Connor's advantage.

Dr. Edward Delos Churchill, Instructor in Surgery, is abroad on a Moseley Travelling Fellowship, and has visited surgical clinics in England, France, Switzerland, Austria, Czechoslovakia and Germany, spending most of his time in clinical observation and pathological work in Sauerbruch's Clinic in Munich.

Dr. Frank Fremont-Smith, Assistant in Neuropathology, is abroad with his family for a year on a Moseley and Rockefeller Travelling Fellowship. He went

MEDICAL SCHOOL ALUMNI BULLETIN

first to the Physiological Congress at Stockholm and then to work under Professor Tannhauser at Heidelberg, where he expected to stay until February and to work on edema. He then goes to Paris and will spend six months, approximately, with Mestrezat, working on spinal fluids.

GENERAL NEWS AND POLICIES

Increase of Tuition:

It has been voted by the Corporation that beginning with the class entering the first year in 1927, and for all subsequent classes, the tuition will be \$400 per year. Coincident with the increase

in tuition there will be provided a loan fund from which students who enter the first-year class in 1927 or thereafter and who are in need of money may borrow. This money will be loaned on business principles. Loans will be made to students in the Second, Third, and Fourth-year Classes, and, in occasional instances only, to men in the second half of the First Year. Loans will be made only to students whose records have been sufficiently creditable to make it altogether probable that they will remain in the School.

Admission:

Beginning this year all applicants residing within fifty miles of Boston are required to have a personal interview with the Assistant Dean or a member of the Committee on Admissions.

Internships:

For the benefit of the Fourth Year students, the School has developed to a far greater point than has been done hitherto an internship information service. Something over a year ago, three sets of circular letters were sent out—the first one to a large number of the teaching staff. It contained a list of the hospitals at which our graduates had

taken internships for the past three years, and asked members of the teaching staff to give their opinion on all internship services concerning which they had direct knowledge. At the same time they were asked if they would be willing to interview students considering such hospitals. The second letter went to all graduates of the last three years, asking them to describe their internships in as illuminating a way as possible for the benefit of the Fourth Year students. The third letter went to superintendents of hospitals, asking them for all available data about their internships, dates, terms of appointment, qualifications, etc. There was a prompt and full response to all these letters; the information was compiled on cards supplemented by a letter file; and the students were informed that it was at their disposal. Recent information from hospitals was posted on a special bulletin board. The students have shown a great interest in these records, and of the 134 men in the present senior class over 100 have been to the office to consult this information service, and many of them have come over and over again and have spoken very warmly of the help that has been given them in this way.

ALUMNI NOTES

1867

Sidney S. Hall, who passed his 83rd birthday March 1, 1927, is an honorary member of the Wisconsin and Minnesota State Medical Societies.

1870

R. N. Carver has recently retired from practice.

1871

Bennett T. Davenport reports that he is now retired after 50 years of business.

1880

After 47 years of practice in Lowell, Wm. B. Jackson announces that he is about to retire.

H. Warren White is now located at 11 Crawford Street, P. O. Grove Hall, Mass.



Vanderbilt Hall, 1967

Welcome to HMS

125 new medical students registered on September 15, 1967 (assuring, among other things, their future membership as alumni in the Class of 1971). In addition, five new students have joined the Second Year Class of 1970, and 50 new students have transferred into the Third Year Class of 1969. Their names, undergraduate colleges and where they took their first two years of medical training are herewith listed. The total number of Harvard Medical School students enrolled in all four classes for the coming academic year is 558.

Abbott, A. Travis
Asheville, N. C. (U. of North Carolina)

Ablett, Charles T.
Los Altos, Calif. (Grinnell)

^d**Albert, Thomas W.**
Beverly, Mass. (U. of Massachusetts)

Alexander, Judith L.
New York, N. Y. (Radcliffe)

Allen, Robert P.
Armonk, N. Y. (Allegheny)

Bahr, Robert L.
Manhasset, N. Y. (Williams)

Baker, Robert A.
Cleveland, Ohio (Dartmouth)

Banks, Peter M.
Quincy, Mass. (Williams)

^d**Baumer, Alex J.**
Auburn, Maine (Tufts)

Bear, David M.
Akron, Ohio (Harvard)

Beart, Robert W., Jr.
Park Ridge, Ill. (Princeton)

Berson, Frank G.
Chelsea, Mass. (Yale)

Billings, J. Andrew
Los Angeles, Calif. (Amherst)

Binder, Andrew S.
Teaneck, N. J. (Williams)

Boey, John H.
Brooklyn, N. Y. (Princeton)

Boger, William P., 3d
Wayne, Pa. (Amherst)

^d**Brackman, Joseph L.**
Newton Centre, Mass. (Harvard)

^d**Bunch, William M.**
Superior, Ariz. (U. of Arizona)

Burch, John W.
Framingham, Mass. (U. of Michigan)

Burke, Donald S.
Novelty, Ohio (Western Reserve)

^d**Burnett, Paul R.**
Wakefield, Mass. (U. of New Hampshire)

Carmel, Richard J.
Los Angeles, Calif. (U. of California, Berkeley)

Cassimatis, Emmanuel G.
Athens, Greece (U. of Chicago)

^dSchool of Dental Medicine

Chapman, Robert S.
Darien, Conn. (Harvard)

Charlton, Valerie E.
Bronx, N. Y. (Radcliffe)

Chase, J. Samuel
Waban, Mass. (Harvard)

Christiansen, John M.
Salt Lake City, Utah (Harvard)

Compeau, Phillip E. C.
Rochester, N. Y. (U. of Rochester)

Cooper, Gale S.
White Plains, N. Y. (Smith)

Craig, William R.
Sacramento, Calif. (U. of Oregon)

Crofoot, David D.
Omaha, Nebr. (Stanford)

Curd, John G.
Golden, Colo. (Princeton)

Donaldson, Magruder C.
Lincoln, Mass. (Harvard)

Duffy, David L.
Port Washington, N. Y. (Amherst)

Eron, Lawrence J.
Millburn, N. J. (Princeton)

^dFeldau, Elliot V.
Swampscott, Mass. (Clark U.)

Feldman, George B.
Union, N. J. (Massachusetts Inst. of Tech.)

Finberg, Harris J.
Providence, R. I. (Brown)

Fineberg, Harvey V.
Pittsburgh, Pa. (Harvard)

Fisher, Charles P.
Fall Church, Va. (Harvard)

Fishman, Robert S.
Teaneck, N. J. (Tufts)

Fossum, Jane E.
Fargo, N. Dak. (Vassar)

Frisch, Lawrence E.
Portland, Oregon (Reed)

Fuller, Arlan F., Jr.
Melrose, Mass. (Bowdoin)

^dGallagher, F. Edward
Worcester, Mass. (Princeton)

Gilchrest, Barbara A. D.
Rye, N. Y. (Massachusetts Inst. of Tech.)

Girshon, Deanna P.
Jersey City, N. J. (Rutgers)

Glass, Allan R.
Fairfield, Conn. (Harvard)

Goldman, Mark R.
Pittsburgh, Pa. (Massachusetts Inst. of Tech.)

Goodfellow, Robin I.
Yellow Springs, Ohio (Western Reserve)

Goodson, William H., 3d
Kansas City, Mo. (U. of Missouri)

Goodwin, James S.
Washington, D. C. (Amherst)

Gould, Robert M.
Great Neck, N. Y. (Brown)

Graves, Howard C.
Salt Lake City, Utah (Stanford)

Graze, Peter R.
Jamaica, N. Y. (Tufts)

Greenberger, Joel S.
Pittsburgh, Pa. (Columbia)

Guyton, Robert A.
Jackson, Miss. (U. of Mississippi)

Hamilton, John D.
Arlington, Va. (Princeton)

Hansbrough, John F.
Madison, Wis. (U. of Wisconsin)

Hashimoto, Frederick
Chicago, Ill. (Yale)

Haynes, Ormond L., Jr.
Fairmont, W. Va. (Williams)

Hickman, Janet K. G.
Mankato, Minn. (Michigan State U.)

Hickman, Robert E.
Benton, Ill. (U. of Illinois)

Hughes, John B.
Haverford, Pa. (Yale)

^dIndresano, A. Thomas
Melrose, Mass. (Boston U.)

^dJacobs, Jonathan S.
Long Beach, N. Y. (U. of Rochester)

Janicki, Paul C.
Elm Grove, Wis. (Marquette)

Jones, Frederick L.
Mt. Lebanon, Pa. (U. of Virginia)

Jones, George T.
Ravenna, Ohio (Harvard)

Karpinski, Richard H. S.
Philadelphia, Pa. (St. Joseph's Coll., Pennsylvania)

^dKelly, John P. W.
Milton, Mass. (Boston Coll.)

Kenny, Peter C., 3d
Great Neck, N. Y. (Providence)

Kissel, John H.
St. Louis, Mo. (Georgetown Univ.)

Klein, Robert S.
Jamaica, N. Y. (Columbia)

Kolff, Cornelis A.
Cleveland Heights, Ohio (Allegheny)

Koopman, William J., 3d
Knowle, Warwickshire, England
(Washington and Jefferson)

Landis, Dennis M. D.
Portuguese Bend, Calif. (Harvard)

Lange, Vladimir
Flushing, N. Y. (New York U.)

Lease, John R.
Somerset, Pa. (Yale)

Lebwohl, David J.
Ossining, N. Y. (Yale)

Leslie, Bruce R.
Brooklyn, N. Y. (Harvard)

Lewis, Collins E.
North Brunswick, N. J. (Rutgers)

Lindsey, Harold E., Jr.
Decatur, Ga. (Univ. of South Carolina)

^dLipnicki, John J.
Bayonne, N. J. (St. Peter's)

London, Charles D.
Beverly Hills, Calif. (Harvard)

Lowe, David A.
Dorchester, Mass. (U. of Massachusetts)

Lyman, Bruce T.
New London, Conn. (Bates)

Lytle, Bruce W.
Fargo, N. Dak. (Stanford)

McClung, Jean P.
Lawton, Okla. (Radcliffe)

McDonald, Eugene J., Jr.
Washington, D. C. (Harvard)

Manders, Ernest K.
Coos Bay, Oregon (Harvard)

Meyer, Allen F.
Plainfield, N. J. (Yale)

Mickley, Steven P.
Belmont, Mass. (Bowdoin)

Milford, Edgar L., Jr.
Nanuet, N. Y. (Harvard)

Murray, Alexandra J.
DeKalb, Ill. (Radcliffe)

Nathan, Carl F.
Pound Ridge, N. Y. (Harvard)

Neumann, Kurt H.
Royal Oak, Mich. (U. of Michigan)

Nierenberg, Michael A.
Wilmington, Del. (Oberlin)

Orkin, Stuart H.
New York, N. Y. (Massachusetts Inst. of Tech.)

Orme, James F., Jr.
Salt Lake City, Utah (Yale)

Pagon, Roberta V. A.
Rochester, N. Y. (Stanford)

Patricelli, Peter M.
Seattle, Wash. (Harvard)

Pierce, Letitia P.
Baltimore, Md. (Vassar)

Pohl, Richard L.
Lynbrook, N. Y. (Princeton)

Popper, Charles W.
New York, N. Y. (Princeton)

^dPosteraro, Anthony F., Jr.
Larchmont, N. Y. (Fordham)

Raetz, Christian R. H.
Hamden, Conn. (Yale)

Reider, Horace O.
Rosemont, Pa. (U. of North Carolina)

^dReisman, Richard J.
Newton Centre, Mass. (U. of Massachusetts)

Rigberg, Corey N.
Philadelphia, Pa. (Harvard)

Robbins, Ann C.
Metuchen, N. J. (Mount Holyoke)

Rosenbaum, Richard B.
Portland, Oregon (Harvard)

Rosenberg, Mark L.
Montclair, N. J. (Harvard)

Rosenblatt, Roger A.
Alexandria, Va. (Harvard)

Ruskin, Jeremy N.
Rockville Centre, N. Y. (Tufts)

Schnitzer, Thomas J.
Baltimore, Md. (Princeton)

Schwartz, Harry C.
Brooklyn, N. Y. (Brooklyn Coll. of The City
U. of N. Y.)

Schwartz, Joel H.
Brooklyn, N. Y. (U. of Pennsylvania)

Seinsheimer, Frank, 3d
Cincinnati, Ohio (Yale)

Sennett, Jordan A.
Milwaukee, Wis. (Harvard)

Shelton, Rufus W., Jr.
Trussville, Ala. (Harvard)

Siatkowski, Raymond E.
Shillington, Pa. (Cornell U.)

Sigelman, Jesse L.
Staten Island, N. Y. (Haverford)

Spiegel, Allen M.
Brooklyn, N. Y. (Columbia)

Spiegel, David
New York, N. Y. (Yale)

Stamm, Walter E.
Portland, Oregon (Stanford)

Stark, James J.
Palisade, N. J. (Yale)

Strunk, Brian L.
Coatesville, Pa. (Princeton)

Sviokla, Sylvester C., 3d
Brockton, Mass. (Harvard)

ten Broeke, John W.
Ridgefield, Conn. (Wesleyan)

Thomas, Robert J.
Ossining, N. Y. (Boston Coll.)

Verlenden, W. Lane, 3d
Lookout Mountain, Tenn.
(U. of North Carolina)

Voralik, Frank J.
Glendale, Calif. (Columbia)

Wallyn, Robert H.
Homewood, Ill. (Coll. of the Holy Cross)

Walsh, B. Timothy
Chevy Chase, Md. (Princeton)

Walter, Paul D.
Johnston, Pa. (U. of Pittsburgh)

Weng, Ssu I.
New York, N. Y. (Radcliffe)

Whiffen, John R.
Madison, Wis. (U. of Wisconsin)

Wickner, William T.
Bethesda, Md. (Yale)

Wing, Edward J.
Port Washington, N. Y. (Williams)

Young, James B.
Tarentum, Pa. (Coll. of Wooster)

Class of 1970

Cox, Malcolm C. L.
U. of Witwatersrand

Kark, Elizabeth C.
Mt. Holyoke (Oxford)

Munford, Robert S.
Vanderbilt (Oxford)

Polonsky, Derek C.
U. of Witwatersrand

Tucker, Robert W., 3d
Dartmouth (Oxford)

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Horner, Richard J.
(Dartmouth) Dartmouth

Kahn, Felicia H.
(U. of Calif., Berkeley) Downstate

Kaiser, Richard A.
(Dartmouth) Dartmouth

Kark, John A.
(Oxford) Oxford

Kramer, Robert J.
(Stanford) Stanford

Kroll, Stephen S.
(Dartmouth) Dartmouth

Lamar, Judy A.
(Radcliffe) Dartmouth

Lawrencee, John M.
(Stanford) U. of S. Dakota

Liang, Matthew H.
(Johns Hopkins) Dartmouth

Little, John W., 3d
(Dartmouth) Dartmouth

Livingston, Philip O.
(Princeton) Dartmouth

Macdonald, John S.
(Dartmouth) Dartmouth

Markworth, James W.
(Dartmouth) Dartmouth

Miles, Richard R.
(U. of Nebraska) U. of Nebraska

Mitchell, Tamara M. T.
(U. of Chicago) U. of Chicago

Montgomery, Stephen L.
(Boston U.) Dartmouth

Nisnla, Bruce C.
(Dartmouth) Dartmouth

Noe, Joel M.
(Harvard) Dartmouth

Osborne, Barbara E. M.
(Radcliffe) Dartmouth

Osborne, David P., Jr.
(Dartmouth) Dartmouth

Passero, Michael A.
(Dartmouth) Dartmouth

Reece, Richard W.
(Princeton) Dartmouth

Reese, Richard E.
(Dartmouth) Dartmouth

Rogers, Malcolm P.
(Yale) Dartmouth

Rudy, Steven M.
(Harvard) Dartmouth

Stopford, F. Woodhall
(Dartmouth) Dartmouth

Swanson, Michael W.
(Wesleyan) Dartmouth

Viglotti, Joseph F.
(Johns Hopkins) Dartmouth

Wegmann, Thomas G.
(U. of Wisconsin) U. of Wisconsin

Class of 1969

Altman, Leonard C.
(U. of Pennsylvania) Harvard Sch.
Dental Medicine

Bail, Richard N., Jr.
(Bowdoin) Dartmouth

Berger, Phil A.
(Dartmouth) Dartmouth

Botstein, Paula M.
(Radcliffe) Wayne State

Bratberg, Jerald J.
(Augustana) U. of S. Dakota

Brooks, John G. 3d
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Bush, David C.
(Dartmouth) Dartmouth

Cecere, MaryAnn
(Radcliffe) Dartmouth

Chiappa, Keith H.
(Harvard) Oxford

Corkery, Richard F., Jr.
(Dartmouth) Dartmouth

Decesare, Ronald E.
(Johns Hopkins) U. of N. Dakota

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Donn, Richard
(U. of Vermont) Dartmouth

Everson, Lloyd K., Jr.
(U. of N. Dakota) U. of N. Dakota

Fee, Henry J., Jr.
(State U. of Iowa) U. of N. Dakota

Feldman, Joel J.
(Dartmouth) Dartmouth

Freeman, John R.
(Dartmouth) Dartmouth

Gutowski, Edward P.
(U. of N. Dakota) U. of N. Dakota

Harken, Laurel D. S.
(Denison U.) Western Reserve

Henderson, James R.
(Bowdoin) Dartmouth

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Tears without grief

Crying Spells—psychic tension with depressive symptoms?

"I don't know what's the matter with me lately...I cry and I cry... and I really don't know why I do."

A woman often is not conscious of the real reasons for her crying spells or refuses to admit them to herself. On probing, you may find that frequent weeping, like insomnia or neurotic fatigue, often is an expression of psychic tension. She needs sympathy and reassurance, and perhaps a calming agent to help her over her crisis. Consider prescribing Valium (diazepam) for her. It usually reestablishes calmness promptly. Crying spells and other secondary depressive symptoms normally subside as the tension is relieved. Your patient then can cope more easily with stresses to which she is subjected. Valium (diazepam) is generally well tolerated, and on proper maintenance dosage usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as

needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function.

Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also

reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged over dosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. **Geriatric patients:** 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

Roche Laboratories, Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



Valium® (diazepam) Roche®

*useful for the relief of
psychic tension with associated
depressive symptoms*

